AN INDEPENDENT ASSESSMENT

California Medi-Cal Specialty Mental Health Services Consolidation Waiver

Prepared By:
Office of State Audits and Evaluations
Department of Finance

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DEPARTMENT OF FINANCE

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November 6, 2002

Ms. Gail Margolis, Deputy Director
Department of Health Services
Medi-Cal Care Services
714 P Street, Room 1253
Sacramento, CA 95814

Dear Ms. Margolis:

Final Report—Independent Assessment: California's Medi-Cal Specialty Mental Health Services Consolidation Waiver

Enclosed is the final report on our independent assessment of California's Medi-Cal Specialty Mental Health Services Consolidation Waiver (SMHSC waiver program). We determined that the SMHSC waiver program resulted in improved access and quality of care throughout California, and that the program is cost-neutral. The Department of Health Services' response and our comments thereon are included in the final report.

It is our understanding that the Department of Health Services will transmit this final report to the Centers for Medicare and Medicaid Services, as a required part of the waiver renewal process.

We appreciate the assistance and cooperation of the Department of Health Services, Department of Mental Health, county mental health plans, and advocate groups with our assessment. If you have any questions about our report, please call Richard R. Sierra, Manager, or Frances P. Parmelee, Supervisor, at (916) 322-2985.

Sincerely,

Samuel E. Hull

Samuel E. Hull, Chief
Office of State Audits and Evaluations

Enclosure

cc: Mr. Bob Bonkowski, Chief, Freedom of Choice Unit, Department of Health Services
Ms. Teri Barthels, Chief, Systems Implementation & Support, Department of Mental Health

ICC: C/F, PARMELEE, OLSEN, NUNES, WHITE, JOHNSON, TODD, BERKE

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EXECUTIVE SUMMARY

California's mental health programs currently operate under the Medi-Cal Specialty Mental Health Services Consolidation Waiver (SMHSC waiver program) authorized under Section 1915(b) of the Social Security Act. The SMHSC waiver program resulted in the creation of 54 mental health plans (MHP), which provide consolidated specialty mental health services, including outpatient and psychiatric inpatient hospital services. Sutter County and Yuba County operate a single MHP established under a joint powers agreement while the Placer County Mental Health Department serves as the MHP for both Placer County and Sierra County. San Mateo County and Solano County operate under different waiver programs. Although actual implementation dates varied across counties, the inpatient and outpatient portions of the SMHSC waiver program have been in effect in California since early 1995 and late 1997, respectively.

The Department of Finance's Office of State Audits and Evaluations (OSAE) entered into an agreement with the Department of Health Services (DHS) to perform an independent assessment of the SMHSC waiver program. This independent assessment is a requirement of the Centers for Medicare and Medicaid Services (CMS),[1] and is a condition of the waiver renewal. CMS provides general direction for conducting an assessment, including the following components: an evaluation and determination of beneficiary access to services under the SMHSC waiver program, an evaluation of the quality of services provided under the SMHSC waiver program, and an assessment of the cost effectiveness/neutrality of the SMHSC waiver program.

DHS, in consultation with the Department of Mental Health (DMH), developed an assessment work plan based on CMS guidelines, and we developed specific tasks to accomplish those objectives and goals. Performance of these tasks allowed us to assess the access, quality of care, and cost-effectiveness/neutrality of the SMHSC waiver program.

The process descriptions, issues, and observations described in this Report are based on our interviews, chart reviews, and document inspection conducted at DMH, various beneficiary and provider advocate groups, and ten selected county MHPs. The ten counties reviewed are Butte, Kings, Los Angeles, Napa, Orange, Placer, Sacramento, San Bernardino, Santa Clara, and Tuolumne.

Evaluation of Access

One goal of the SMHSC waiver program is to improve accessibility to specialty mental health services for Medi-Cal beneficiaries. We evaluated four core qualitative access elements: gatekeeping functions, availability of patients' rights and choice information, 24/7 emergent and urgent-care capacity, and outreach to targeted and under-served populations. We also analyzed certain quantitative performance elements, including penetration rate trends, county

[1] Formerly the Health Care Financing Administration (HCFA).

standings in relation to the statewide average, and regional variations in penetration rates across California. We determined that under the policies and procedures implemented by MHPs, access to specialty mental health services for Medi-Cal beneficiaries has improved since the implementation of the SMHSC waiver program.

Although access to services can be identified as one of the SMHSC waiver program's greatest strengths, some areas of concern were identified, including:

- Lack of standards governing provider capacity and providers' self-assessment of capacity.
- Inequitable MHP supplementation of the State Maximum Allowance (SMA) to recruit and/or retain "high-demand" providers.
- Historical inequitable MHP funding bases and resulting effects on current utilization and penetration rates.
- Shortages of general and child psychiatric services and the resulting appointment delays and waiting lists.
- Insufficient numbers of hospital beds and step-down facilities.
- Uneven statewide provision of Medi-Cal reimbursable services.
- Changes to the formerly separate and distinct Fee-For-Service and Short-Doyle mental health networks.
- Use of Notice of Actions (NOA) to regulate and restrict access to mental health services.

Evaluation of Quality

In addition to improving access, the SMHSC waiver program was intended to enhance quality of services. We identified, analyzed, and researched significant elements affecting the quality of services, including coordination of care, continuous care methodologies, cultural competence, the Rehabilitation Option, credentialing of providers, and quality management programs.

Overall, the quality of services has improved due to the SMHSC waiver program. Although we acknowledge the program's many strengths that led to our conclusion, some areas of concern include:

- Barriers to overall coordinated care include the disconnect between county-operated/contracted and network fee-for-service providers, the inconsistent sharing of treatment results among providers, and the inconsistent provision of case management to mental health beneficiaries.
- Inconsistent statewide ability to discharge beneficiaries to lower levels of care, possibly resulting in increased inpatient readmission rates and hospital administrative days.
- Lack of a State special incident reporting system for outpatient services.
- MHPs not at risk for medication costs.
- Inconsistent statewide scope of quality assurance systems, especially pertaining to provider chart reviews.
- Inconsistent statewide methodologies and periodicity requirements for preparation and update of assessments and client plans.

Performance Outcome Data Analysis

The Performance Outcome System measures quality of services through client completion of various instruments. We reviewed statewide requirements for performance outcome data collection and analysis. Assessment instruments are available for youths, adults, and older adults (currently a pilot project), and indicate data assessment targets, survey populations, and periodicity. We recognize that DMH is constantly reviewing and improving this evolutionary process. Two main areas of concern at county mental health departments are: (1) the constant change that occurs to the Performance Outcome System; and (2) the general confusion regarding the purpose and reliability of reports generated from the collection of the performance instruments.

Chart Reviews

We conducted beneficiary chart reviews at the ten visited MHPs to determine documentation practices. To maximize review effectiveness, we used a chart review question guide in conjunction with our chart review mechanism to identify county practices and to document certain non-clinical attributes of beneficiary charts. We also performed a limited fiscal review to determine whether approved claims are supported, and participated in site reviews at several provider facilities to gain insight into the practical aspects of service delivery. Inherent diversity among MHPs, coupled with county flexibility to design responsive programs, naturally fosters statewide disparity. The main areas of concern include:

- Ambiguous statewide chart documentation and periodicity requirements lead to inconsistencies among county MHPs.
- Absence of centralized review of treatment results from all concurrent providers is exacerbated by the infrequent sharing of charts among providers.
- Inconsistent use of Management Information Systems, particularly by network fee-for-service providers.
- Inconsistent provision of case management services to mental health beneficiaries, particularly regarding assignment of targeted case managers.
- Inconsistent inclusion of quality of life assessments in beneficiary charts.
- Infrequent medication reviews by other than the prescribing physician.
- Lack of charting requirements for cultural competence, universally embraced as a worthwhile element of care.
- Infrequent and inconsistent quality assurance monitoring of provider charts, particularly of network fee-for-service providers.
- Inconsistent statewide methodologies and periodicity requirements for preparing and updating of assessments and client plans.

Advocate Group Perspectives

To obtain representative insight into their perspectives, we met with several beneficiary and provider advocate groups. It is important to note that the opinions voiced in that Chapter are not those of the independent assessors. Advocates' insight regarding the access, quality, and cost-effectiveness of the SMHSC waiver program covered various areas. Overall, advocates believe that California would best be served by the SMHSC waiver program's continuation.

Cost-Effectiveness Analysis

To determine the waiver's cost effectiveness/neutrality, staff comprehensively reviewed and analyzed the waiver renewal request and exhibits, the subsequent information submittals, and other information obtained from DHS and DMH. We also interviewed numerous representatives of these entities, as well as other professionals involved in generating the estimated cost data. We determined that during the waiver period, the program was cost effective/neutral.

To determine this, we performed certain recalculations and examined the State's methodology for determining cost-effectiveness, and evaluated the State's calculated Upper Payment Limit (UPL) that estimates the cost of services without the SMHSC waiver program. The main areas of concern include:

- The methodology used to calculate the CMS-approved UPL is based only on historical trends, and does not provide accurate estimates because actual data becomes obsolete, as unpredicted changes in environment take place.
- Early Periodic Screening Diagnoses and Treatment (EPSDT) program costs represent 40 percent of overall waiver costs and 70 percent of increases in waiver costs for all three years. Those costs are projected to continue to grow at a large rate.
- EPSDT costs are not tracked by MHPs because the State requires no oversight of EPSDT expenditures.

Conclusion/Recommendations

Overall, we concluded that the SMHSC waiver program has improved both access to and quality of services while maintaining cost-effectiveness/neutrality. Although we acknowledge the program's many strengths, we also recognize the need for improvement in this still-evolving program. While we can provide general recommendations for some of the statewide inconsistencies, risk areas, and other issues identified, many require consideration and analysis by DMH to determine the most appropriate course of action. Our recommendations are as follows:

- DMH should instruct counties to issue NOAs in all cases of service denial to ensure a more comprehensive accounting of these decisions for statewide monitoring purposes.
- DMH should promulgate regulations requiring an increased level of capacity monitoring for network fee-for-service providers, to reduce the incidence of service delays.
- Develop statewide guidelines and best practices to provide guidance and assistance to help ensure that MHPs operate at optimal levels. Draft a State Quality Improvement Plan to coordinate oversight efforts and support MHPs.
- Enhance the existing special incident reporting system to include reportings on outpatient care. Revise the annual compliance review protocol to include a review of such reportings.
- Implement a plan for monitoring medication utilization trends in order to identify unusual fluctuations and promote appropriate use of resources.
- Revise the methodology used to calculate the UPL. The calculations should be performed by an actuary, or based on a sound methodology, similar to that contained in the DHS *Upper Payment Limit Rate Methodology Manual.*

- Use unduplicated beneficiaries instead of number of Medi-Cal beneficiaries in calculations for the UPL. Currently, the SMHSC waiver program is not capitated and therefore, should not use the Per Member Per Month calculation in its UPL.
- The State should implement program controls requiring the MHPs to track EPSDT expenditures.
- The State should employ monitoring of the SMHSC waiver program's cost effectiveness.

PREFACE

Effective November 20, 2000, the Health Care Financing Administration (HCFA) approved California's request for a two-year continuation of the Medi-Cal Specialty Mental Health Services Consolidation Waiver (SMHSC waiver program) authorized under Section 1915(b) of the Social Security Act. The approval provided a waiver of three Social Security Act sections for 54 mental health plans. Specifically, the approval waived sections 1902(a)(1) Statewideness, 1902(a)(10)(B) Comparability of Services, and 1902(a)(23) Freedom of Choice, in order to permit California to continue operation of the SMHSC waiver program through November 19, 2002.

HCFA, now the Centers for Medicare and Medicaid Services (CMS), approved continuation of the SMHSC waiver program on the condition that an independent assessment be performed three months prior to the waiver termination date. The independent assessment calls for an evaluation of access to services, quality of care, and cost-effectiveness of services. The California Department of Health Services contracted with the Department of Finance to perform the required assessment.

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Background

In 1991, overburdened local mental health departments received relief from the Bronzan-McCorquodale Act (Chapter 89, Statutes of 1991), commonly known as "realignment." This law aimed to offset a $14.3 billion state budget deficit that was all but crippling county programs. The statute called for a 0.5 percent tax increase in the state sales tax and a 24.33 percent increase in vehicle license fees, to be earmarked specifically for mental health, social services, and a health trust fund for county needs. These realigned funds, matched by the counties, have become the primary revenue stream for county-based systems. While county boards of supervisors have 10 percent leeway to decide where realignment funds may go, the majority presently remains in mental health services.

California's decision to initiate the Rehabilitation Option (Rehab Option) as part of its Medi-Cal approach created new avenues for promoting mental health. The medically centered Clinical Option, along with other traditional health care models, had been under intense scrutiny throughout the last quarter of the 20th century. The medical profession itself was under the microscope. Does the traditional approach to care address the needs of beneficiaries throughout the health industry? Is medication the most effective mode of care? If not, what other treatment modalities might augment or supplant it? Regarding mental health, should psychiatrists be the dominant figure in assessment, diagnosis, and treatment? If not, what other clinical training may be deemed legitimate? If institutional settings are necessary for the most severely mentally ill beneficiaries, where should care be provided to less ill beneficiaries? Alternative care methods became more commonplace as theorists and practitioners stretched for new techniques to help their beneficiaries. In conjunction with these fundamental questions, clinicians on the front line were trying to deal with the day-to-day struggles of meeting the needs of the mentally ill while managing the bureaucratic regimes placed on them. County line staff, strapped with growing caseloads and under-funding searched for creative techniques to supplement resource shortfalls. Out of this broad array of cultural and professional challenges, the Rehab Option gave root.

In 1993, California adopted the Rehab Option, which was allowed by Medi-Cal. The Rehab Option opened Medi-Cal reimbursement eligibility to a wide range of licensed practitioners - psychiatrists, psychologists, licensed clinical social workers, and marriage, family, and child counselors. Delivery of mental health services may be located in a variety of sites rather than in the traditional clinic setting. And while medical treatment, i.e. the use of medication as the initial starting point, has in no way been dismissed, new emphasis has been placed on life enhancing components and functional community acclimation skills training.

In 1995, California opened a new chapter in its public health system. At the time, Medi-Cal beneficiaries could access mental health services through two separate avenues: the Fee-For-Service Medi-Cal system (FFS/MC) or the Short-Doyle Medi-Cal system (SD/MC). Under FFS/MC, beneficiaries exercised free choice in selecting a service provider. Providers included clinics, hospitals, private practitioners, and other facilities enrolled in the FFS/MC

program. Ideally, a consolidated effort through coordination, and an integrated service module should provide the efficiency and cost effectiveness that California was looking for.[2]

The Department of Health Services (DHS) requires the Department of Mental Health (DMH) to direct 58 relatively autonomous counties in their efforts to meet the goals of managed care.[3] To this end, DMH has encouraged counties to opt into the Medi-Cal Specialty Mental Health Services Consolidation Waiver program (SMHSC waiver program). It allows a county mental health department, referred to as a mental health plan (MHP), to limit beneficiary access to a specific pool of services and practitioners. This approach gives MHP administrators greater control over program selections.

The SMHSC waiver program, approved by the Centers for Medicare and Medicaid Services (CMS), was scheduled for renewal assessments in 1997,1999, and 2002. Consolidation, under the SMHSC waiver program, was mapped out in phases including Psychiatric Inpatient Hospital Services, Specialty Mental Health Services, and a Pre-Pay System. To gain waiver approval, the State[4] must show that beneficiary access to Medi-Cal services has not been impaired.

Formerly, DHS allotted standardized federal financing participation (FFP) rates for inpatient psychiatric hospital services to private practitioners through FFS/MC. Phase I redirected allocations so that MHPs became the single point of authorization, payment, and monitoring for private providers. Rates were now contracted based on state and federal regulations.

Phase II consolidated "specialty mental health services," referring to types of therapies and ancillary services provided by specialists who performed their functions in outpatient and hospital settings. Now, an assortment of clinicians, services, and treatment environments were coordinated under one authority that could manage the structure of access and types of available therapy.

Phase III, in a state of abeyance, proposes to share fiscal responsibility between the counties and the State through risk-based liability sharing. Risk liability relies on performance outcome data as a program assessment and management tool. Currently under development, risk management aims to analyze the factors that contribute to the total program picture, i.e. participant demographics, service frequency, therapy modalities, et al., to evaluate future efficiency and cost effectiveness. While this has the potential to prudently focus funding and efforts, risk still continues as an experimental evaluative technique. To be successful, significant factors need to be determined and isolated from static data so that consistent formulas can be used across diverse fields of study. DMH continues to hone its own techniques for outcome data development and retrieval. Performance outcome has become the byword in finding best practices models to be used as standards for consistent assessment across MHPs.

[2] California Mental Health Master Plan (Draft), California Department of Mental Health, 2001 revision date, Chapter 7, p. 89, "Managed care, broadly stated, is a planned, comprehensive approach to providing health care that combines clinical services and administrative procedures within an integrated, coordinated system."
[3] For the complete directive, see California Code of Regulations (CCR) Title 9, Division 1, Chapter 11.
[4] For the purpose of this report, the Department of Health Services is referred to as the "State."

Scope of the SMHSC waiver program

Section 1902 of the Social Security Act lays the foundation for Medi-Cal managed health care standards, promoting consistency across the nation. The SMHSC waiver program loosens state obligations to certain programmatic mandates, allowing for greater state directed programs, policies, and reimbursements. Federal lawmakers created this option to encourage local cost containment initiatives, which would maintain, and not exceed, current federal disbursements. The SMHSC waiver program promotes plan improvement in three significant areas - access, quality, and cost effectiveness/neutrality. DMH continues to develop a comprehensive protocol coordinating a patchwork of highly diverse counties toward general systematic guidelines that help navigate federal criteria.

Access measurements significantly define the success of Medi-Cal programs by describing the demographic groups that enter county systems of care. Penetration rates record the number of non-duplicated enrolled eligible beneficiaries that use Medi-Cal services, compared to the entire eligible population. Medi-Cal beneficiaries are more inclined to receive services when they become aware of their own eligibility and the availability of services they want and need. Therefore, it makes sense to provide services that work best for targeted populations within a given region.

The SMHSC waiver program alleviates the requirement for statewideness, which dictates that all programs offered under State authority are provided to Medi-Cal beneficiaries throughout California. Originally set in place to ensure equal access, statewideness places burdens on counties that might share little demographic commonality with other counties. Tailoring services for specific local needs allows counties to use their limited resources more effectively. Areas that help DMH ensure MHP compliance with standards include:

- Quality is assessed by tracking provider qualifications, suitability of services, and beneficiary movement from higher end levels of care to lower ones. Each of these categories indicates whether beneficiaries are benefiting from their services. While standardized health plans may assist managers with general care regimens, each beneficiary requires a treatment plan specifically fashioned to meet particular individual needs.
- Comparability of services requires that services be equal in quantity and quality across need categories. The SMHSC waiver program allows the State to authorize the addition, expansion, and alteration of services to county programs. Services cannot be limited below federal guidelines.
- Cost effectiveness/neutrality gauges whether comparable SMHSC waiver program service expenditures are below, meet, or exceed pre-waiver levels.

The SMHSC waiver program allows MHP administrators to restrict the choices of service providers. Beneficiaries receive care from providers who are deemed by the MHP to possess appropriate technical skills. As a cost control mechanism, rates are negotiated prior to contract, rather than allowing fees to remain open-ended. Also, because providers are contractually bound within the county apparatus, they must comply with state and federal regulations to receive payments. This allows counties to more effectively scrutinize performance outcomes from fee-for-service providers. In this way, resource use is confined to providers and services that yield the most success. The goal is to consolidate SD/MC and FFS/MC into one coordinated system of care.

Role of Government Agencies

The federal agencies, state departments, and county MHP administrators have made tremendous strides in moving local mental health programs toward more accessible, cost effective formats that integrate a variety of services into "seamless" systems of care.

Federal regulations steer the direction of California's efforts toward consolidated managed care. Detailed federal codes are developed to advance community-based mental health systems with an aim to meet the specific needs of Medi-Cal beneficiaries. Regulations often bring a heavy economic component that local agencies must shoulder to remain in compliance. Block grants, special project funds, and other incentives have been offered to reduce local program burdens. DMH uses these guidelines and revenues to promote organizational standards that qualify MHPs for federal funding. State and county administrators are continually challenged to create arrangements that meet federal conditions while maintaining the greatest degree of autonomy. Operational and assessment standards are often difficult to apply due to the very diverse demographic demands placed on each of the 58 counties.

Additional tension arises due to the need for uniform performance outcome measures as a means to justify expenditures brought on by federal mandates. Developing and enforcing appropriate, standardized assessment measures has been a persistently difficult task for DMH. MHPs are required to provide encounter data to receive federal and state allocations. Unfortunately, the counties are reluctant to participate in data collection, citing DMH's lack of consistent criteria for measurements and a clear direction regarding their use. DMH demonstrates a willingness to develop usable criteria through its many studies that explore the parameters of outcome measure technologies. However, DMH is often caught in the middle – trying to placate federal regulators while attempting to extract information from reluctant counties. The challenge then is to give required data to federal agencies that may not be readily forthcoming. This conflict of purposes, identified throughout the course of fieldwork, is the underlying dynamic between the various levels of government.

Counties use various federal and state regulations and guideline documents to design systems of care that most fully conform to the specific needs of beneficiaries. Implementation plans[5] are developed with DMH authorization to work in compliance with federal mandates. The State allows each county to choose admittance into the managed care system. Presently, 54 MHPs have entered into agreement.

[5] CCR Title 9, Section 1810.310.

SCOPE/METHODOLOGY

Scope

The Department of Finance, Office of State Audits and Evaluations (OSAE), entered into an interagency agreement with the Department of Health Services (DHS) to perform an independent assessment of California's Medi-Cal Specialty Mental Health Services Consolidation Waiver program (SMHSC waiver program), as stipulated under Section 1915 (b) of the Social Security Act. This statewide independent assessment is mandated by the federal Centers for Medicare and Medicaid Services (CMS) and is a condition of the waiver renewal. San Mateo County and Solano County implemented different waiver programs and are therefore excluded from this assessment. State Medicaid Manual, Section 2111(B), Part 2 authorizes another entity within the state government that is not responsible to the Medicaid State Agency, DHS, the Department of Mental Health (DMH), or the agency responsible for administrating the waiver program, to conduct this assessment. OSAE meets this independence requirement.

The December 22, 1998 State Medicaid Director's Letter included a CMS publication entitled *"Independent Assessments: Guidance to States."* These guidelines were developed to provide federal direction requiring that the assessment of the SMHSC waiver program evaluate and determine: (1) beneficiary access to services; (2) quality of services; and (3) the cost effectiveness/neutrality.

Methodology

DHS, in consultation with DMH, developed and provided us with a proposed assessment work plan. We identified specific activities necessary to achieve goals and objectives contained in the work plan. However, because not all required data was readily available, we were unable to measure or achieve all objectives delineated in the work plan. These objectives did not impair our ability to provide an overall assessment of the SMHSC waiver program.

We conducted our assessment in several phases, over approximately six months. We met with over 100 county representatives, spoke with seven beneficiary and provider advocate groups; and communicated with DMH representatives from units such as the Office of Multi-Cultural Services, Statistics and Data Analysis, and Technical Assistance and Training. We also reviewed other supplemental documentation such as prior Independent Assessments, other reports and publications, and governing rules and regulations, as listed in the References. We gathered, reviewed, and analyzed relevant background information, materials, reports, and data to familiarize ourselves with current implementation of the SMHSC waiver program and State and County oversight and monitoring responsibilities.

County MHP Site Visits

In order to address access, quality, and cost-effectiveness/neutrality of the SMHSC waiver program, we conducted site visits at ten county Mental Health Plans (MHPs).[6] DMH selected a geographically representative sample based on criteria provided by OSAE. Via telephone conference, CMS was given advance notification of the MHP selections. The purpose of the site visits was to gather information relevant to the implementation of the SMHSC waiver program and evaluate operation of the program, but not to evaluate individual MHPs. At the end of each site visit, an exit conference with key personnel was held to discuss outcomes and receive necessary clarification on outstanding issues.

We developed a three-fold approach to conduct each MHP site visit. This approach included informal fact-finding interviews with county staff, review of county policy and procedures, and chart reviews.

Fact-Finding Interviews

We conducted interviews in each county to develop a preliminary understanding of MHP structure and operation. Using the DHS work plan and CMS guidelines, we developed a patterned question guide to help ensure that our interviews were as comprehensive and consistent as possible. DMH provided visited counties with advance notice of interview topics. Topic areas included overview and context, access, quality, and fiscal issues.

We asked MHP management to select county staff for interview participation based on their expertise in the topic areas. Interviews were conducted informally in a discussion-oriented manner to facilitate information gathering. In addition to providing understanding of MHP operations, informal interviews also elicited insight not readily apparent from review of county policy and procedure documentation.

Review of Policy and Procedure Documentation

At each MHP, we reviewed relevant background information, materials, reports, and data to acquaint ourselves with county-specific implementation of the SMHSC waiver program. We reviewed the following types of documentation (to the extent available) at each MHP:

- Organizational charts
- Provider and consumer satisfaction results
- Compliance and grievance logs
- Cost report data
- Strategic plans and cultural competence plans
- Provider manuals
- Beneficiary handbooks and handouts
- Memorandums of Understandings
- Other statistical and relevant data provided by the MHPs

[66] See Table 1 for listing.

Chart Reviews

We conducted beneficiary chart reviews at each of the ten visited MHPs to determine documentation practices for services. Although DMH requires counties to address certain standards (assessments, client plans, progress notes)[7] in beneficiary charts, MHPs have discretion over the means by which these are addressed and documented, so long as they comply with laws and regulations. Our goal was to determine how these standards are addressed and documented statewide.

During our first site visit at Napa County MHP, we created a chart review mechanism based on review of various source documentation, including the California Code of Regulations, Title 9, Chapter 11; the chart review monitoring protocol used by DMH;[8] and chart documentation standards required by the DMH contract with MHPs.[9] Due to the highly iterative nature of this assessment, our mechanism was streamlined and updated prior to use at the nine remaining counties. This led to inconsistencies between review results in Napa County and the remaining nine counties. To foster continuity of presented results, Napa County is not included in our review summary. Our mechanism containing summarized review results for the remaining nine counties is presented in Appendix 1.

In addition to our chart review mechanism, we also prepared a list of questions designed to help us gain an understanding of MHP chart documentation and review standards. We viewed this question guide as a working document and subjected it to modifications throughout fieldwork. Questions served as a guide to help us better understand charting requirements in each county. We did not necessarily ask all questions in each county.

DMH provided a list of 25 beneficiaries for Los Angeles and 15 beneficiaries for the remaining counties, based on criteria approved by OSAE. These criteria called for a random sample, stratified by age,[10] drawn from the population of beneficiaries who received at least two services from January 1, 2001 to June 30, 2001, for which Short-Doyle/Medi-Cal (SD/MC) claims were approved. We provided beneficiary lists to MHPs approximately one week prior to our site visits.

With the exception of Kings County, all MHPs identified beneficiaries selected by DMH as beneficiaries served by their MHP. Due to an input error, none of the beneficiaries selected for Kings County were part of the Kings County MHP. We worked with Kings County staff to select a new sample following the above criteria, except that the sample was not stratified by age.

In total, 145 beneficiaries were selected for chart review at the MHPs, excluding Napa. Counties were unable to provide charts for six of these beneficiaries. At least one chart was provided for each of the remaining 139 beneficiaries. We requested MHPs to provide, to the extent possible, all provider (county-operated, contracted, network fee-for-service) charts for each beneficiary. Although many MHPs were able to obtain and provide county-operated and contracted provider charts, most were unable to provide network fee-for-service provider charts. When it was provided, documentation from network fee-for-service providers was often incomplete and could not be effectively reviewed. In total, we reviewed 156 charts for 139 beneficiaries at nine MHPs. Our review results are documented in Appendix 1.

[7] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C.
[8] Annual Review Protocol For Consolidated Specialty Mental Health Services and Other Funded Services Instructions to Reviewers for 2001/02 prepared by DMH.
[9] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C.
[10] "Stratified by age" means charts were selected based on each of the three age groups' distribution percentage in each county. For example, if age group 0 – 20 comprises 65 percent of the total population in County A, 65 percent of charts selected for that county will be for clients aged 0 – 20.

We focused our review for required documentation and key elements on the period 1998 through present. Although several charts reviewed were opened prior to 1998, we felt chart practices documented between 1998 and present are most indicative of current practices. As such, we did not review chart documentation prior to 1998. We reviewed charts for evidence of the following non-clinical attributes:

- Coordinated/managed care
- Targeted case management
- DSM IV diagnosis that meets Impairment and Intervention criteria from Title 9
- Quality of Life Assessments
- Medication reviews (periodic and secondary)
- Cultural/linguistic services (cultural competence)
- Planned vs. episodically responsive intervention/treatment
- Involvement of beneficiary's parent/guardian/caregiver/family, etc.
- Assessments, diagnoses, client/treatment plans
- Progress notes documenting services provided

In conjunction with our chart review, we also performed a limited fiscal review to determine whether claimed billings were supported by source documentation. As discussed above, DMH provided a list of beneficiaries for each county we visited. These lists included an itemization of each beneficiary's approved SD/MC claims for services rendered from January 1, 2001 to June 30, 2001. The scope of our fiscal review was limited to determining the existence of supporting documentation for the approved claims for the stated time period. We did not attempt to ensure that all services documented in beneficiary charts were billed, approved, and paid; nor did we attempt to determine whether claims from other time periods were supported.

Our fiscal review was intended to provide limited assurance that billed claims were supported. To do this, we traced claims to progress notes, assessments, and other chart information that documents time spent. Because this fiscal review was secondary to our chart review, we performed this review in only half of the counties visited.[11] Additionally, we only performed this fiscal review on charts we received. As mentioned before, we did not receive charts from all contracted and network fee-for-service providers. Results of our review are presented in the Chart Review Chapter.

To supplement information obtained from chart reviews and to gain insight into the practical aspect of service delivery, we visited several provider facilities. Although no specific review was undertaken or patterned questions asked during these site visits, we obtained a general idea of the layout and operations of the provider facilities to enhance our understanding of implementation of the SMHSC waiver program. In total, we visited 23 provider sites as listed in Table 1.

[11] We performed fiscal reviews in Napa, San Bernardino, Sacramento, Tuolumne, and Los Angeles.

Table 1—County MHP and Provider Facility Field Visits

County	Field Visit Dates	Provider Facilities Visited
Napa	Feb. 4 - Feb. 6, 2002	- No facilities visited in this county.
Placer	Feb. 26 - Mar. 1, 2002	- No facilities visited in this county.
San Bernardino	Feb. 26 - Mar. 1, 2002	- Day Treatment Facility (1) - Dual-Diagnosis Day Rehabilitation Program (2)
Orange	Mar. 18 - Mar. 22, 2002	- Child and Adolescent Day Treatment Facility (2) - Outpatient Clinic (1) - Crisis Intake Center (2) - Acute Psychiatric Inpatient Unit (2)
Sacramento	Apr. 2 - Apr. 5, 2002	- Crisis/Inpatient Treatment Center (1) - Child and Adolescent Psychiatric Outpatient Clinic (1) - Adult Outpatient Clinic (2)
Kings	Apr. 8 - Apr. 11, 2002	- Child and Adult Outpatient Clinic (1) - Drop-In Center (1)
Butte	Apr. 9 - Apr. 12, 2002	- Psychiatric Health Facility (1) - Drop-In Center (1)
Santa Clara	Apr. 15 - Apr. 18, 2002	- Crisis/Inpatient Treatment Center (3) - Child & Adolescent Outpatient Clinic (2)
Tuolumne	Apr. 22 - Apr. 24, 2002	- Acute Psychiatric Inpatient Unit (3) - Board & Care Facility (2) - Drop-In Center (2) - Day Treatment Facility (2)
Los Angeles	Apr. 29 - May 3, 2002 May 6 - May 8, 2002	- Integrated Service Agency (2) - Inpatient Hospital & ER (1) - Community Treatment Facility/Psychiatric Health Facility (2) - Institution for Mental Disease (2)

(1) County-operated provider
(2) Contracted provider
(3) Network fee-for-service provider

Performance Outcome Data Analysis

In assessing quality of services, it is important to consider beneficiary perspectives. Unfortunately, we were unable to meet with sufficient numbers of beneficiaries to obtain data representative of opinions of the whole population. As such, we chose to review results of various performance outcome instruments designed to measure beneficiary satisfaction with the quality of services. We opted to present DMH's statewide survey results. We realize that these results include non-Medi-Cal beneficiaries; however, there are no survey results specific to the SMHSC waiver program.

Advocate Groups

In assessing access to and quality of services, it is important to consider perspectives from all sides. Unfortunately, we were unable to meet with sufficient numbers of providers and beneficiaries to obtain data representative of opinions of the whole population. As such, we chose to meet with advocate groups to help obtain a clear picture of the SMHSC waiver program's effectiveness. Advocate organizations raise issues, concerns, or positive attributes of the SMHSC waiver program from both beneficiary and provider perspectives.

We solicited eleven beneficiary and provider advocate groups for input based on statewide representation. Only four of the five beneficiary groups and four of the six provider groups accepted our request to provide input. For the most part, those that declined expressed a moderate level of comfort with the SMHSC waiver program or indicated that their input may be insignificant due to their indirect involvement with the SMHSC waiver program. Although we attempted to meet with advocates in person, a few groups chose to provide their perspectives by telephone rather than in person.

Assumptions

The descriptions, issues, and observations of California's mental health delivery system described in this report are based on staff and advocate groups interviews, chart reviews, document inspection conducted at DMH and selected MHPs, and a literature review of pertinent documentation listed in the References. Because we could not meet with staff from each county, our descriptions, issues and observations of California's mental health delivery system may not be representative of specific waiver implementation by each county within California. However, due to the nature and extent of our review of geographically representative MHPs, we believe our process descriptions, issues, and observations constitute a representative depiction of the SMHSC waiver program's implementation.

Throughout our review, we made assumptions, applied certain methodologies, and relied on certain information. We reviewed the SMHSC waiver program, as communicated and available, and did not test accuracy or propriety of statements or underlying data. The following assumptions were consistently made, applied, and relied on throughout our review:

- We accepted the propriety of various statistical and financial information provided by DMH, DHS, and the visited MHPs. This information includes, but is not limited to, data from the Cost & Financial Reporting System and data related to Medi-Cal eligibility, paid claims, length-of-stay/recidivism, and performance measures.
- We accepted implementation practices and procedures as described by DMH, DHS, and MHP staff. Except for our review of charts, we did not test or attempt to verify that described practices were, in fact, applied.
- We accepted the propriety of clinical information provided by DMH, DHS, and/or the visited MHPs. Specifically, we did not perform a clinical review in any facet of this assessment and we limited our observations to issues for which a clinical background is not necessary.

One primary goal of the Medi-Cal Specialty Mental Health Services Consolidation Waiver (SMHSC waiver program) is to improve the accessibility of specialty mental health services for Medi-Cal beneficiaries. We examined the following core access elements:

- Gatekeeping functions
- Availability of patients' rights and choice information
- Emergent and urgent-care capacity (24/7)
- Modes of outreach to targeted and under-served populations
- Quantitative analysis of access
- Areas of concern

Gatekeeping Functions

The original concept of "gatekeeping" refers to the use of primary care physician referrals as the initial step towards specialty mental health care access. For the purpose of this report, the term gatekeeping has extended the designation to describe any filtering or "screening" of potential beneficiaries in an attempt to limit access to certain groups within a given population.[12]

To meet regulatory expectations of the SMHSC waiver program, the task of gatekeeping includes screenings to assess medical necessity as a means of testing service eligibility under Medi-Cal reimbursement criteria. Gatekeeping provides pre-evaluation prior to a more rigorous clinical assessment leading to the beneficiary's treatment plan and full involvement in the mental health plan (MHP). To a large extent, the gatekeeping function has been standardized by the requirements to meet medical necessity. The presence of medical necessity criteria provides a uniform starting point for MHP staff in screening potential beneficiaries eligible for services. It is this uniformity that helps ensure a level of equity in accessing mental health services between different counties, and represents the foremost strength of the access function.

Gatekeeping responsibilities have been distributed to a wider range of staff, including non-Licensed Practitioners of the Healing Arts (LPHA). Offered rationale for the use of less-trained individuals centers on the scarcity of licensed clinicians. MHP administrators also have indicated that target-population criteria make over-the-phone evaluations fairly straightforward, asserting that screening takes less clinical training. Some counties have moved away from using LPHAs entirely, relegating the gatekeeping job to bachelor level paraprofessionals or even interns (who are supervised by an LPHA).

Although target populations and medical necessity criteria appear to be well defined, there are still some issues complicating the gatekeeping function. All visited counties indicated that their clinicians would err on the side of admitting or referring individuals for services offered by the MHP, rather than redirecting them to their primary care physician for general mental health

[12] California Code of Regulations (CCR), Title 9, Section 1810.310 (a)2A, WIC 5600.2(b), WIC 5600.3+.

services. The crux of this issue centers on whether counties should legitimately deny access to beneficiaries with primary care physicians. Approximately one-third of visited counties believed that this was an issue requiring further clarification from the Department of Mental Health (DMH).

Patients' Rights

As a condition of the SMHSC waiver program, DMH is required to monitor MHP complaint and grievance procedures. To this end, DMH has established a protocol and created units within the department that work together to specifically monitor MHPs. County grievance procedures are outlined in County Implementation Plans submitted to DMH and subject to the contract agreements between DMH and MHPs.

The grievance protocol includes DMH and MHP monitoring for both service access and authorization. MHPs are entitled to receive assistance from DMH's Technical Assistance and Training (TAT) Unit. All complaints and grievances must be responded to in a timely and sensitive manner. Counties are required to provide a written notice of acknowledgement to beneficiaries within five days of the complaint, followed by a resolution within 30 days. The counties ensure that information regarding the process, as well as brochures and pamphlets relating to services and programs offered through the MHP, is available to beneficiaries when they enter the system.

California Code of Regulations (CCR), Title 9, Chapter 11, requires counties to seek mediation of informal disputes at the county level. During county annual compliance reviews, the Compliance Review Team randomly inspects outpatient incident reports. The MHP's Quality Improvement Committee or other assigned personnel monitor the complaint or grievance process according to the protocol set forth in the county contract.

The complaint and grievance process represents one of the most important rights to MHP beneficiaries. As such, the process receives a great deal of attention from MHP staff. In most of the counties surveyed, the process falls under the control of the quality improvement committee. Working closely with the patient advocate, quality improvement staff focus on addressing complaints through extensive documentation and review. In a limited number of counties, the patient advocate staff handles this function. Irrespective of where the responsibility for the monitoring and resolution falls, a high level of cooperation between the quality improvement and the patient advocate functions exist, providing the necessary linkage to resolve most complaints before they rise to the level of a grievance.

Emergent and Urgent Care Capacity

The SMHSC waiver program also requires 24/7 urgent and emergent care capacities. Specifically, Title 9 regulations state:

> "Each MHP shall make specialty mental health services to treat a beneficiary's urgent condition available 24 hours a day, seven days a week . . . Each MHP shall provide a statewide, toll-free telephone number 24 hours a day, seven days per week . . . that will provide information to beneficiaries about how to access specialty mental health services, including services needed to treat a beneficiary's urgent condition."[13]

[13] CCR, Title 9, Chapter 11, Section 1810.405(c)(d).

Unlike medical necessity criteria, 24/7 coverage is handled differently among the various MHPs. For example, in some of the larger and more complex MHPs, staff is available 24 hours a day to screen calls and handle beneficiaries. In smaller and less specialized MHPs, after-hours calls may be forwarded to a call screening service for attention. Further, some MHPs have made arrangements with local hospital psychiatric wards to handle after-hours calls. Liaisons or coordinators stationed at county-operated and contracted hospitals facilitate access to inpatient services, and make the necessary referrals to outpatient services upon discharge from the hospital setting. Most of the surveyed counties had contracts in place with every emergency room within their county, thus reducing the chance of denial to critical services in times of crisis. Despite differences in the level of access-related services, all counties well exceeded the threshold requirements for 24/7 emergent and urgent care capacities.

Modes of Outreach

MHPs' outreach efforts endeavor to serve eligible underserved populations. Two components distinguish outreach from other access functions: (1) MHPs must provide information that educates entitled groups; and (2) MHPs must have a strategy for sending staff to geographic areas where "hard-to-reach" beneficiaries dwell. It is the MHP's responsibility to draw Medi-Cal eligibles into the full scope of benefits.[14] The following summary describes outreach efforts to three historically underserved populations: children, elder adults, and the homeless and incarcerated. A fourth underserved group, those faced with linguistic and cultural barriers to services, will be discussed in the Evaluation of Quality Chapter.

MHPs attempt to handle complex and personal issues in a sensitive manner by disseminating mental health care information and establishing a presence in many school districts. The extent of their involvement on a given campus can range from part-time counselors and therapists to full-scale clinic services. Memorandums of Understanding (MOU) between MHPs and school districts continue to expand as the schools recognize the interrelationship between their role and influence in the lives of adolescents.

In addition to outreach to children, MHPs also make a concentrated effort to bring older adults into the service delivery fold. Elder adults are often homebound, lacking access to transportation. Therefore, many MHPs have created older adult care units, taking services directly to elderly beneficiaries. MHPs have established linkages with other relevant social service agencies to proactively identify the needs of this population.

In many cases, the homeless and the incarcerated are not amenable to accessing county mental health services. These eligible beneficiary groups require effort to move toward care. Rather than allowing conditions to grow so acute that long-term care is required, substantial resource savings can occur with early intervention. Consequently, many MHPs attempt to reach out to the homeless in an effort to give them the mental health services they might not secure on their own. MOUs and coordinated joint outreach efforts with law enforcement and homeless agencies were taking place in most of the counties. Additionally, AB 34 (Steinberg) enacted by the California Legislature in 1999 provides comprehensive outreach and integrated mental health therapy to at-risk homeless and incarcerated populations. The program has proven successful enough to secure additional funding from the Legislature in the form of AB 2034. There are 35 programs currently operating statewide, serving about 4,800 persons. Although these programs are not part of the SMHSC waiver program, they complement DMH's outreach efforts through linkages to services and assistance with the Medi-Cal eligibility process.

[14] CCR, Title 9, Chapter 11, Section 1810.310(a)(2)(B); WIC Sec 5600.2(d) and 5614(b)(5).

Quantitative Analysis of Access

In addition to performing a qualitative analysis, we also considered a quantitative measurement of access performance. Known as the "penetration rate," this measurement is defined as the number of unduplicated MHP beneficiaries divided by the number of total Medi-Cal eligible beneficiaries. DMH provided data including the rate at which Medi-Cal beneficiaries accessed outpatient mental health services during fiscal years 1998-99 and 1999-00.[15] DMH provided data for 55 MHPs (Sutter and Yuba counties are reported together). Data was analyzed for the following trends:

- Penetration rates
- Relative standing of counties in relation to the statewide average
- Regional variations in penetration rates

Penetration Rates

Data presented in Table 2 reveals a positive change in the penetration rate from 1998-99 to 1999-00 for 47 of the 55 MHPs (85.5 percent). The consolidation of outpatient services in 1998 was intended to bring about a widely available level of services located in less acute outpatient settings. The data suggests that outpatient mental health consolidation has resulted in increased penetration rates in the short run.

County vs. Statewide Averages

A second analysis involves the relative ranking of county penetration rates as compared to the statewide average, and the change in these relative rankings from 1998-99 to 1999-00. Specifically, in 1998-99 and 1999-00, 38 of the 55 MHPs (69.1 percent) and 37 of the 55 MHPs (67.3 percent), respectively, ranked above the statewide average penetration rate. The statewide average penetration rates in 1998-99 and 1999-00 were 5.8 percent and 6.2 percent, respectively.[16] Although the number of counties above California's average decreased by one, two-thirds of MHPs remain above the statewide average. This is a reasonable indication that access to services is fairly stable across counties.

Table 2—County Penetration Rates and Statewide Averages

County	Penetration Rate 99/00	Penetration Rate 98/99	Penetration Rate Change 98/99 to 99/00	County Above Statewide Average in 99/00	County Above Statewide Average in 98/99
Alameda	6.8	6.7	0.1	Yes	Yes
Alpine	0.5	0.8	-0.3	No	No

[15] "Performance Measurement Data," California Department of Mental Health, January 2002.

[16] Statewide penetration rate percentages presented in this Chapter differ immaterially from percentages presented in the Cost Effectiveness Analysis Chapter; data were obtained from different units within DMH.

	Penetration Rate 99/00	Penetration Rate 98/99	Penetration Rate Change 98/99 to 99/00	County Above Statewide Average in 99/00	County Above Statewide Average in 98/99
Amador	9.2	8.3	0.9	Yes	Yes
Butte	7.8	7.2	0.6	Yes	Yes
Calaveras	5.1	5.5	-0.4	No	No
Colusa	4.3	6.4	-2.1	No	Yes
Contra Costa	8.1	7.8	0.3	Yes	Yes
Del Norte	13.6	13.3	0.3	Yes	Yes
El Dorado	8.7	7.6	1.1	Yes	Yes
Fresno	4.8	4.5	0.3	No	No
Glenn	5.7	6.1	-0.4	No	Yes
Humboldt	8.4	7.7	0.7	Yes	Yes
Imperial	4.5	4.1	0.4	No	No
Inyo	5.3	4.9	0.4	No	No
Kern	7.9	7.2	0.7	Yes	Yes
Kings	7.1	6.6	0.5	Yes	Yes
Lake	7.2	6.9	0.3	Yes	Yes
Lassen	7.7	6.6	1.1	Yes	Yes
Los Angeles	5.1	4.8	0.3	No	No
Madera	5	4.6	0.4	No	No
Marin	12.5	11.5	1	Yes	Yes
Mariposa	8.2	7.5	0.7	Yes	Yes
Mendocino	6.8	5.7	1.1	Yes	No
Merced	4.4	4.1	0.3	No	No
Modoc	12.8	9.2	3.6	Yes	Yes
Mono	2.2	2.9	-0.7	No	No
Monterey	3.9	3.9	0	No	No
Napa	7.3	7.2	0.1	Yes	Yes
Nevada	10.8	8.5	2.3	Yes	Yes
Orange	6.6	6	0.6	Yes	Yes
Placer	10.4	8.7	1.7	Yes	Yes
Plumas	8.6	9.2	-0.6	Yes	Yes
Riverside	6.4	6.1	0.3	Yes	Yes
Sacramento	6	4.9	1.1	No	No
San Benito	6	6.3	-0.3	No	Yes
San Bernardino	5.8	5.3	0.5	No	No
San Diego	8.1	7.4	0.7	Yes	Yes
San Francisco	11.7	11.6	0.1	Yes	Yes
San Joaquin	7.2	6.4	0.8	Yes	Yes
San Luis Obispo	9	7.7	1.3	Yes	Yes
Santa Barbara	7.1	7	0.1	Yes	Yes
Santa Clara	7.3	7.2	0.1	Yes	Yes
Santa Cruz	8.7	8.7	0	Yes	Yes
Shasta	9.1	8.3	0.8	Yes	Yes
Sierra	2.5	2.1	0.4	No	No
Siskiyou	13.3	12.2	1.1	Yes	Yes
Sonoma	8.1	7.7	0.4	Yes	Yes

County	Penetration Rate 99/00	Penetration Rate 98/99	Penetration Rate Change 98/99 to 99/00	County Above Statewide Average in 99/00	County Above Statewide Average in 98/99
Stanislaus	7.2	6.7	0.5	Yes	Yes
Sutter/Yuba	6.3	5.8	0.5	Yes	No
Tehama	9.4	9.2	0.2	Yes	Yes
Trinity	8.5	9.2	-0.7	Yes	Yes
Tulare	4.7	4.3	0.4	No	No
Tuolumne	12.3	12.3	0	Yes	Yes
Ventura	5.8	5.6	0.2	No	No
Yolo	8	7.9	0.1	Yes	Yes

Regional Variations

A final noteworthy trend is the regional association with decreases in penetration rates. In particular, seven of the eight MHPs experiencing a decrease in penetration rates from 1998-99 to 1999-00 are located in the Central or Northern regions of California. These regions represent classifications developed by DMH to divide the MHPs by region for data analysis purposes. The Central Region includes central and southern valley and mountain counties. The Northern Region includes northern valley and mountain counties. The fact that seven of eight MHP's with decreasing rates are located in these two regions may indicate that other demographic factors exert an influence on penetration rates.

Overall, penetration rates for the two fiscal years indicate a positive trend in relation to access. The majority of counties experienced increased penetration rates for the two-year period. Furthermore, two-thirds of the counties remained above the statewide average penetration rate. Although this two-year penetration rate trend is positive, a word of caution must be observed concerning this analysis. The data set for the two fiscal years is very limited in its explanatory potential. Other demographic factors not related to the implementation of the SMHSC waiver program may affect a particular county's ranking relative to the statewide average.

Areas of Concern

These issues are not directly connected to specific criteria or regulations, but represent current trends and practices encountered in the review of the surveyed MHPs. These issues represent areas of concern, in terms of their potential implications on access. The most critical areas are:

- Provider ability to self-assess capacity and the lack of standards governing provider capacity.
- County supplementation of the State Maximum Allowance (SMA) to recruit and/or retain particular providers.
- The uneven historical funding base for counties and the relationship it has to current utilization and penetration rates.
- The shortage of general and child psychiatric services, and resultant waiting lists and appointment delays.
- Hospital bed shortages and the lack of step-down facilities.
- The uneven provision of Medi-Cal reimbursable services.
- Changes to the fee-for-service networks.
- The use of Notice of Actions (NOA) to regulate and regiment access to mental health services.

Provider Capacity

Capacity self-assessment and the lack of uniform standards governing provider capacities are important access concerns. Although an appropriate level of monitoring is performed for county-operated and contracted providers, the same types of requirements are not consistently imposed on fee-for-service providers. We found that most of the ten MHPs allow fee-for-service providers to self assess their Medi-Cal caseload capacity without county input. Some MHPs may question the providers when anomalies arise, but aside from such incidences, formal standards are not implemented. One large MHP stated that its providers are monitored on a reactive basis, meaning that action is taken if a beneficiary files a complaint or grievance. This lack of monitoring could result in providers over-estimating their capacity levels which could lead to excessive waiting periods for beneficiaries to receive services. DMH regulations requiring more rigorous monitoring of fee-for-service provider capacity may help to reduce service delays.

Supplementation of the State Maximum Allowance

In most counties, supplementation of the State Maximum allowance (SMA)[17] occurred in an effort to recruit and retain particular providers. The issue raises two questions: (1) is supplementation a violation of Medi-Cal laws and regulations; and (2) does supplementation of the SMA promote uneven or inequitable levels of access to services across counties?

With respect to the first issue, Medi-Cal law would appear to prohibit counties from "patching" or supplementing the SMA for many of their specialty mental health services. According to DMH staff, the only explicit prohibition against supplementation involves Early Periodic Screening Diagnosis and Treatment Program (EPSDT) dollars. While we found no regulations prohibiting supplementation, our review found nothing currently in place to formally promote this mechanism.

Aside from concerns related to the legality of supplementation, consideration was given to potential uneven levels of access. Specifically, if resource-advantaged counties have the ability to supplement the SMA, then it is possible for them to provide services that may not be available to beneficiaries in other counties. In the surveyed counties where supplementation occurred, its purpose was to provide psychiatric services in the private FFS/MC office-based setting or deliver mental health services to deaf beneficiaries at a private specialty hospital. It appears that supplementation predominately occurs in higher cost-of-living areas. This situation may indicate that appropriate justification for supplementing reimbursements in higher cost counties may exist.

Historical Funding Inequities

The historical funding inequities that have developed in the mental health system is another significant access issue. The process for establishing present funding levels in each county may not permit the level of access and services originally envisioned under the SMHSC waiver program. A DMH planning document describes the situation:

> "During the development of the SD/MC program in the late 1960's, some counties were aggressive in matching dollars and others were not. As a result, historical inequities in funding developed. These inequities were compounded when many counties did not pursue the 50 percent federal match for SD/MC either. As a result, those counties had far less resources for providing mental

[17] Medi-Cal's maximum level of payable reimbursement per service incident.

> health services to the beneficiaries in their communities. These inequities continue to present-day because the funding formula for realignment reflects the original matching formulas and each county's individual level of participation prior to the enactment of realignment."[18]

Some in the mental health community have suggested that inequities between counties have led to uneven levels of access to services. Disparate funding levels can likely affect MHPs in many ways, including adverse effects on utilization rates, penetration rates, and quality of services. The likelihood that funding inequities influence other access areas is also possible. However, an analysis of funding inequities is beyond the scope of this assessment.

Shortage of Psychiatric Services

The shortage of available clinicians is one of the most obvious challenges for all MHPs. There are discernable access delays related to the general statewide shortages of mental health professionals, especially child psychiatrists. In particular, the numbers of graduating medical students entering psychiatric residency programs have been steadily decreasing, while the number of beneficiaries needing mental health services has been increasing. In a presentation to the California Mental Health Planning Council's (Planning Council) Human Resource Committee in June 2001, Craig Van Dyke, MD, Chair, Department of Psychiatry, University of San Francisco, reported that the University of California and California's private medical schools produced 152 psychiatry school graduates. Realistically, the mental health field probably needs thousands of professionals to accommodate the demands of the mental health services delivery system. This shortage is felt nationally, with California ranked 9th in the nation in psychiatrists per capita, with 12.9 psychiatrists per 100,000 population.[19]

In most of the counties reviewed, this shortage leads to appointment delays and waiting times that range from two to eight weeks. The delay can be further exacerbated in particular counties where culturally competent professional services are scarce and/or locations are not desirable. Adding to the potential inequity in psychiatric service availability is the competition for trained personnel between counties. A number of counties indicated that competition could be quite fierce. Disparities in pay and benefit packages and geographical locations may make the difference in securing qualified personnel. In general, larger counties have the ability to offer more lucrative pay and benefit packages to potential employees.

The shortage of psychiatrists essentially relegates them to prescribing medication. Psychiatrists are sometimes involved in adult and child therapy sessions; however, their level of involvement is highly regimented by case managers or access team workers performing the aforementioned gatekeeping role. This infrequent level of involvement results in licensed or waivered clinicians and paraprofessionals, under the supervision of an LPHA, performing much of the preliminary and provisional-level diagnoses.

In March 2000, in response to this crisis, the Planning Council convened the Human Resources Summit, involving key decision-makers. The goal was to develop solutions and action plans for this human resource problem that affects all levels of the mental health system. The Planning Council also sponsored another summit covering innovative curricula for various occupations and distance learning. The summit was designed to initiate a planning process in each region for regional training centers, which would enhance the collaboration between MHPs, community agencies, postsecondary institutions, and other resources for recruiting students and

[18] California Mental Health Master Plan (Draft), California Department of Mental Health, 2001 revision date.
[19] Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Information and Analysis; http://bhpr.hrsa.gov.

employees. The Planning Council also facilitated meetings of specific academic disciplines, such as nurse practitioners, to expand the capacity of programs centering on multicultural and multilingual recruitment.[20] Organizers hope the efforts of various stakeholders will alleviate practitioner shortages.

Lack of Step-Down Facilities

Another issue some MHPs face is the lack of step-down facilities providing less restrictive levels of supported care. Over the last two decades, adult residential facilities and foster homes have been closing due to a lack of profitability for providers, increased licensing requirements and regulations, and negative community responses. Providers found it more equitable to make a switch and serve developmentally disabled beneficiaries. Foster care home providers are faced with economic struggles, and community resistance regarding their presence in residential neighborhoods. One Bay Area MHP stated that providers were finding it more beneficial to sell their high valued properties rather than establish care facilities.

Decreasing facility accessibility has forced many MHPs to place beneficiaries in less than appropriate levels of care. For example, one county placed a 98-year-old dementia beneficiary in a psychiatric facility for nearly a year because other alternatives were not available. Although this is an extreme case, MHPs deal with similar types of problems on a regular basis, especially for the dually diagnosed[21] and older adult beneficiaries with debilitating physical ailments. Although cooperative agreements are made between agencies that share beneficiary responsibilities, MHPs shoulder the burden of placement. Some MHPs suggest that regional centers resist admitting the developmentally disabled because staff is not adequately trained to care for beneficiaries with severe and persistent mental illnesses. The lack of step-down facilities can increase recidivism; and the number of emergency room admissions, jail admissions, and hospital inpatient administrative days. Again, the Planning Council is working to address California's housing crisis for the mentally ill by investigating the barriers to housing, including funding deficiencies, shortage of affordable housing, "NIMBYism,"[22] licensing restrictions, and a lack of expertise on the part of local mental health communities to access federal and state housing grants.

The shortage of psychiatric hospital beds, especially for certain geographic areas and specific age groups, compounds this placement problem both in California and nationally. An outdated provision of the Medi-Cal program that excludes Institutions for Mental Disease (IMD) from federal financial participation further aggravates the situation. Currently, only two facility categories are used for short-term acute psychiatric care in California: freestanding acute psychiatric hospitals [or psychiatric health facilities (PHFs)], or general acute care hospitals with a psychiatric unit. Both categories meet the hospital conditions for Medi-Cal beneficiaries. However, acute freestanding hospitals are prohibited from serving adult Medi-Cal beneficiaries due to the IMD exclusion, while general acute care hospitals are allowed to treat the same beneficiary and be reimbursed by Medi-Cal.[23] Consequently, many MHPs pay 100 percent of beneficiary care costs. Although the rationale for the IMD exclusion was to protect state and federal government agencies from absorbing all costs of care, perhaps this issue needs to be re-examined.

[20] California Mental Health Planning Council website: www.dmh.cahwnet.gov/mhpc/projects.asp.
[21] "Dual diagnosis" commonly refers to a beneficiary diagnosed with both a severe mental illness and a substance abuse problem.
[22] Term definition: "Not in my backyard."
[23] California Institute for Mental Health, "Psychiatric Hospital Beds in California: Reduced Numbers Create System Slow-Down and Potential Crisis;" August 30, 2001.

Uneven Levels of Service

Beneficiaries who meet medical necessity are eligible for reimbursable treatment under the SMHSC waiver program. Although MHPs are required to provide specialty mental health services to these individuals, there is no specific means by which services must be delivered. There is the possibility that different clinicians will approach treatment of similar impairments in different ways, depending on their specific field of practice.

Consolidation was intended to promote consistent statewide provision of specialty mental health services. However, because demographics and beneficiary needs vary, MHPs were granted discretion to develop individual programs to meet the needs of their clientele, provided that they operate within the confines of applicable laws and regulations.

Although governing laws and regulations provide general guidelines as to types of services that should be provided, there is no designation of specific services that must be offered in each county. This flexibility has naturally led to diversity among counties and has also created uneven provisions of Medi-Cal reimbursable services throughout California. Specifically, providers develop client plans to direct interventions deemed necessary to ameliorate beneficiary impairment. Because counties offer varying levels of service provisions, MHPs may grant access to only a pre-determined number of service visits. There is concern that beneficiaries may also be directed away from certain unavailable community-based treatment options, and instead be treated with medications. These perceived conditions might prompt beneficiaries to discontinue treatment, return to primary care providers, or attempt to receive services at another county's MHP.

Disparities in funding streams (e.g., general and realignment) enable some counties, particularly larger, urban counties, to offer wider arrays of service options. Limited resources increase a county's need to weigh the cost of service options with the demand for those services. Because no two counties would likely make the same choices, there are disparities between MHPs as to levels of services offered. Specifically, one MHP may provide day treatment services in response to high demand (and ability to pay) for such services, while another MHP with lesser demand (or resources) may not. As a result, beneficiaries in all counties may not have access to all forms of treatment, including those that may be effective intervention options. This has prompted some beneficiaries to comparison shop between counties to find the most desirable service options.

MHP representatives cite a tremendous fiscal impact on county budgets as a result of beneficiaries "shopping" for counties offering more service options. Counties struggle to keep pace despite considerable strain on realignment dollars and services. It is particularly difficult for counties that have experienced a heavy influx of migrating beneficiaries. Consideration must be given to both the fiscal and human resource limitations impacting MHPs statewide. Again, these issues have a greater effect on the smaller, more rural counties. Heavy statewide fiscal adjustments would be required to equalize service option levels among MHPs. Without these changes, counties must continue to adjust services to balance beneficiary needs against available resources.

Changes to the Fee-For-Service Provider Network

In addition to variations in the scope of services provided by MHPs, the size and capacity of the fee-for-service provider networks has changed dramatically with the onset of the SMHSC waiver program. These changes to size and capacity of the fee-for-service provider networks raise concerns regarding adequate access to services. In most of the counties reviewed, the provider networks have greatly diminished.

A major reason for the decline in FFS/MC providers is the accountability requirements put in place under the SMHSC waiver program. According to MHP staff, many smaller, individual providers have ended their relationships with the MHP and Medi-Cal beneficiaries due to onerous regulatory requirements. In particular, many smaller providers have balked at mandatory participation in provider training sessions, case files accessibility for MHP inspection, pre-authorization for services to beneficiaries, and other communication and monitoring requirements now imposed as a condition for participation under the SMHSC waiver program.

Notice of Action (NOA) Data

A final noteworthy consideration involves the use of NOAs in the denial of specialty mental health services. Although DMH's TAT Unit examines NOAs during MHPs' annual compliance reviews, the NOA data collected may not reflect all service denials. Specifically, NOAs are only issued if the MHP is the initial point of entry to the system. If a beneficiary does not meet the medical necessity criteria and the MHP is not the initial point of entry, a NOA is not issued. For example, if a dually diagnosed beneficiary is referred for specialty mental health services by a substance abuse program, but does not meet medical necessity, the beneficiary may be referred to other community-based services without receiving a NOA. This can result in a beneficiary's lack of awareness regarding service denial, modification, or deferral.

Although the counties are in compliance with current federal regulations and state requirements, it might be instrumental to issue NOAs in all situations, regardless of the beneficiary's initial point of entry. This would provide a clearer and more realistic picture of actual service denials allowing DMH to improve its monitoring oversight, evaluation of trends, and communication with respective agencies.

Conclusion/Recommendations

Overall, access to specialty mental health services has improved under the SMHSC waiver program. It could be argued that the consolidation of access functions has been one of the SMHSC waiver program's greatest strengths. However, despite the strengths associated with access, improvements can still be made to enhance access to specialty mental health services. While DMH is ultimately responsible for deciding appropriate courses of action, we make the following recommendations:

- DMH should instruct counties to issue NOAs in all cases of service denial to ensure a more comprehensive accounting of these decisions for statewide monitoring purposes.
- DMH should require higher levels of capacity monitoring by network fee-for-service providers to reduce instances of service delay.

California's Medi-Cal Specialty Mental Health Services Consolidation Waiver program (SMHSC waiver program) was designed to improve the quality of Medi-Cal specialty mental health services. In order to obtain approval for the waiver request, the quality of services must not be less than the quality of the services prior to or without the waiver. During the course of our assessment, we identified, analyzed, and researched significant core quality elements that affect the quality of services, including:

- Coordination of care
- Continuous care methodologies
- Cultural competence
- Rehabilitation option
- Credentialing of providers
- Quality management program
- Areas of concern

Coordination of Care

Under the fee-for-service Medi-Cal system (FFS/MC), services could be rendered by county-operated, contracted, or network fee-for-service provider facilities. Under the Short Doyle Medi-Cal system (SD/MC), counties were responsible to provide services through either county-operated or contracted provider facilities. Although both systems were administered at the state level, neither program was delivered by a single entity in each county and there was no single point of responsibility and administration. Further there was no coordinated effort between the two systems. This bifurcated delivery system was not conducive to managed care.

Poor service coordination was compounded by an inherent risk that mentally ill persons seeking treatment in an all-inclusive health care system may not receive the required attention. To resolve these issues and to help ensure successful treatment of persistent and severe mental illness, California "carved out" specialty mental health services from preexisting, general mental and physical health care programs, consolidating the FFS/MC and SD/MC programs under one administrative county Mental Health Plan (MHP).

An important goal of consolidation was to improve levels of coordinated care provided under the prior service delivery approaches. Coordinated care is intended to help ensure that beneficiaries receive needed comprehensive and non-duplicative treatment from county operated, contracted, and network fee-for-service providers.

Although some communication efforts between providers may have existed under the previous bifurcated delivery system, there was no guarantee that treatment was monitored to ensure that complete, non-duplicative services were delivered. The SMHSC waiver program, by consolidating administrative responsibility, increases opportunities for better coordination. Signs of improvement include: (1) coordination between hospitals, outpatient services, and

other agencies; (2) linkage efforts to other community-based services; and (3) coordination with general health care providers.

Quality of care has improved due to the coordinated efforts between inpatient and outpatient services. When a beneficiary receives inpatient care and requires outpatient services, the assigned case manager coordinates with the hospital discharge liaison to ensure that the beneficiary is appropriately linked to outpatient care after discharge. Both parties make certain that beneficiaries obtain outpatient appointments in a timely manner and continue to receive outpatient services. Proper connections to community based services and general health care providers are also continued to foster continuity of care and reduce instances of hospital re-admission.

Continuous Care Methodologies

Not only did the concept of coordinated care become more of a reality due to the SMHSC waiver program, the assurance of continuity of care also became an aspiration for all MHPs. Prior to the SMHSC waiver program, adult beneficiaries who were receiving services through the FFS/MC program were limited to two psychologist services per month and could not obtain Medi-Cal services from licensed clinical social workers (LCSW) or marriage and family therapists (MFT). MHPs were allowed only two mental health therapy encounters per month. Encounters over the threshold amount would not be reimbursed by Medi-Cal. Under the SMHSC waiver program, MHPs have discretion to tailor authorization processes to fit the needs of their individual mental health delivery systems. Larger counties may pre-authorize a certain number of sessions with contracted and FFS/MC providers while smaller MHPs might require that beneficiaries go through an Access Team and be diagnosed before services are authorized.

This flexibility allows counties to provide quality services, lessens bureaucratic procedures for FFS/MC providers, and matches limited resources with areas of greatest need. Through county supplementation of Medi-Cal benefits, MHPs can offer beneficiaries a greater array of services, including those not reimbursed under Medi-Cal. These supplemental services include:

- Advocacy services
- Respite services
- Transportation at minimal or no charge
- Additional clinical visits after loss of Medi-Cal eligibility to ensure continuity of care
- Case management services that easily exceed the basic level of targeted case management services reimbursable under Medi-Cal
- Support groups
- Vocational services
- Educational services
- Residential placement of Medi-Cal beneficiaries between the ages of 21 and 64

Mental and physical health care providers, law enforcement agencies, and community officials are making strides toward working together more closely on mental health issues. Psychiatrists are available to physical health physicians and pediatricians for roundtable discussions on various general mental health concerns, such as medications, treatment practices, and community resources. These communication channels develop alternatives for beneficiaries to receive care from less restrictive environments, such as schools or primary care physicians.

Larger MHPs have had success in training, educating, and collaborating with law enforcement to help them become more responsive to suspected mentally ill persons. Joining forces helps

prevent unnecessary incarceration or hospitalization; provides intervention, referral and placement for mentally ill persons; and expedites the return of law enforcement officers to other duties. One metropolitan MHP certifies law enforcement officers who complete an intensive two-week training course dedicated to mental health awareness. Other MHPs develop teams of officers and clinicians with mobile capabilities to provide on-site resolution alternatives and mental health expertise. Because of these mutual relationships, counties are experiencing fewer emergency room intakes and 5150s,[24] and reduced intakes of individuals with other available resources or funding (such as third party support). These changes help ensure that limited resources are available for allocation to areas of greatest need.

Cultural Competence

Cultural competence awareness and multilingual capability have greatly increased due to mandates of the SMHSC waiver program. Specifically, each MHP set goals to provide culturally competent services ensuring provision of effective communication and quality services to their threshold populations. To meet that goal, each MHP developed and implemented a Cultural Competence Plan that includes the following components in accordance with provisions of the California Code of Regulations, Title 9, Chapter 11 (Title 9):[25]

1. Objectives and strategies for improving the MHP's cultural competence based on assessments and performance standards.
2. Assessments of county populations and of organizational and service providers, focusing on issues of cultural competence and linguistic capability.
3. A listing of specialty mental health services and other MHP services available for beneficiaries in their primary language by service location.
4. A plan for cultural competency training for the administrative and management staff of the MHP, the persons providing specialty mental health services employed by or contracted with the MHP, or with contractors of the MHP.

Different efforts are made across California to expand the various aspects of cultural competence throughout MHP operations. Some counties exceed expectations by identifying and serving high profile groups with significant numbers that fall under the threshold language requirement. The threshold language is identified as a primary language of 3,000 beneficiaries or 5 percent of the beneficiary population, whichever is greater. Some MHPs address stigmas that surround certain groups by opening culture-specific service centers/clinics, such as Los Angeles County's Coastal Asian Pacific Mental Health Clinic, and Santa Clara County's Josefa Chaboya De Narvaez Mental Health Center. Within the cultural communities, these service centers/clinics provide vocational and other rehabilitation services, outreach, crisis intervention, support groups, and educational sessions on various mental health topics. Cultural competence training has also become an integral part of MHP representatives' continuing education.

Vigorous efforts are made to recruit bilingual licensed practitioners from the rather limited pool. MHPs offer attractive packages to entice potential bilingual and/or multi-lingual practitioners. Local university recruitment, stipends for interns placed within the mental health system, and salary differentials are some ways to attract this highly demanded labor force. MHPs located in more desirable locations within California are more able to recruit bilingual employees and can significantly reduce the use of costly resources, such as interpreters and the AT&T Language

[24] WIC Section 5150 states that a beneficiary believed to be either a danger to self or to others, or gravely disabled (i.e., unable to provide for own basic personal needs) may be involuntarily taken into custody for a 72-hour period, for holding and evaluation.
[25] CCR, Title 9, Chapter 11, Article 4, Section 1810.410.

Line. A drawback, however, is that bilingual clinician caseloads are considerably higher than caseloads for non-bilingual clinicians. The nearly doubled caseloads can cause bilingual clinicians to burn out, which could have turnover implications.

At the onset of the SMHSC waiver program, DMH was instrumental in the implementation of cultural competence provisions as required by Title 9. DMH is in the process of reviewing the activities, progress, challenges, and changes of the counties' approved plans. Future strategies include a cursory review of the plans implemented from 1998 to date. Once DMH has analyzed documentation submitted by the counties, they intend to develop appropriate criteria and protocol to incorporate into the annual compliance review process.

Rehabilitation Option

Despite the current statewide shortage of clinicians, the human resource issue improves as the mental health industry moves from the Clinical Option to the Rehabilitation Option (Rehab Option).[26] With implementation of two Medi-Cal State Plan Amendments that added targeted case management and community-based services to the SD/MC scope of benefits, the range of personnel who could provide services, the locations at which services could be delivered, and the types of services available have broadened considerably.[27]

The SMHSC waiver program fosters the Rehab Option by allowing service provision in non-clinical settings by various multi-disciplinary practitioners including LCSWs, MFTs, and MAs. Our beneficiary chart reviews supported MHPs' opinions that consideration of social attributes is an essential component of effective interventions. Specifically, assessments, client plans, and progress notes document that current case management services well exceed the basic targeted case management services reimbursable under Medi-Cal. For example, MHP staff assist beneficiaries with job placements; teach basic skills that move beneficiaries towards independent living; and provide a support system that involves the community, family members, and significant others.

Credentialing of Providers

The SMHSC waiver program encourages MHPs to require all providers in the Medi-Cal system to undergo a formal credentialing process to help ensure services are provided by appropriately licensed and certified practitioners. The process includes collecting and verifying professional credentials, education, training, specialization, qualifications, and evaluating the provider against professional standards and requirements. The National Practitioner Data Bank (NPDB) is queried for adverse actions reported against the provider, such as malpractice, disciplinary actions taken by a state licensing board, or dismissal/suspension from any hospital, agency, or other professional organization. If the NPDB reveals any reported incidents, the application is referred to and reviewed by a higher-level, multi-disciplinary committee.

Although MHPs rely on credentialing processes established by some group and organizational providers, they may still perform a cursory record review including license monitoring and compliance examinations. Other MHPs prefer to review all provider applications, which include county-operated, contracted, and network fee-for-service providers.

[26] The Rehabilitation Option was added, via a State plan amendment, to the array of SD/MC services in 1993. The Rehabilitation Option Manual, used for guidance prior to consolidation, was superceded by laws and regulations governing the SMHSC waiver program.

[27] Medi-Cal Specialty Mental Health Services Consolidation, Section 1915 (b) Request for Waiver Renewal, June 1999, pg. 2.

Quality Management Program

The requirement to implement a Quality Management (QM) program at each MHP has probably been one of the most significant waiver-related enhancements. Title 9 mandates that a QM program should include certain elements such as:[28]

1. A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries that:
    a. Is accountable to the director of the MHP.
    b. Is actively involved in planning, design and execution from providers, beneficiaries, and family members.
    c. Includes substantial involvement of a licensed mental health professional.
    d. Conducts monitoring activities, such as complaints, grievances, fair hearings, appeals, and clinical record reviews.
2. A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP.

DMH has several units that monitor to ensure that beneficiaries receive quality services. Specifically, the Ombudsman's Office, Technical Assistance and Training Unit (TAT), Compliance Unit, and several other units within DMH, perform support services encompassing specific quality improvement functions.

In addition to providing information to beneficiaries about available mental health services, the Ombudsman's Office also responds to complaints, facilitates mediations, and helps beneficiaries navigate through the mental health system. Because the Ombudsman's Office tracks complaint data, significant information is available for consideration in the annual compliance review. DMH uses data collected by the Ombudsman's Office in the following ways:

- Identifies trends about complaints and provides this information to the State Quality Improvement Coordinators.
- Provides MHPs information regarding the nature of beneficiary complaints submitted directly the Ombudsman's Office.
- Generates county specific reports.

The TAT unit supports counties' implementation of their MHPs. The primary role of this highly specialized team is monitoring of contracts between DMH and the counties. Monitoring is handled through phone contracts and on-site visits to the MHPs, follow-up of plans of corrections developed as a result of the annual reviews conducted by the DMH Compliance Division, follow-up of beneficiary and provider complaints, and review of items such as the annual grievance reports and quality improvement work plans. TAT also works closely with other supporting units such as the Quality Improvement Committee, Office of Multicultural Services, Statistics and Data Analysis, Adult and Children's Systems of Care, Managed Care, Compliance, and the Ombudsman's Office.

Although there is no federal or state mandate requiring the use of focus groups, DMH and counties continue to convene and use these groups to acquire beneficiary and family feedback

[28] CCR, Title 9, Chapter 11, Article 4, Section 1810.440.

regarding their experiences with the MHP. DMH uses focus groups as a means to gain insight into quality improvement processes and to help reviewers with oversight protocol issues.

Counties use them to support their annual review process and to accept input from beneficiaries and family members regarding specialty mental health services.

The TAT Unit or Managed Care Unit facilitates statewide focus groups. The composition of focus groups varies by MHP, reflecting each county's unique demographic makeup and levels of service users. Individuals are convened to address beneficiaries' issues/concerns relative to services provided by the MHP. When meetings conclude, a report is prepared and forwarded to the county Quality Improvement Coordinator. Although counties are not required to implement changes in response to issues and concerns raised by focus groups, DMH encourages counties to use this information to make county programs more responsive to their beneficiaries' needs.

Another measure initiated prior to the annual compliance review is the formation of the Compliance Advisory Committee. This ad hoc group is comprised of hospital administrators, mental health directors, beneficiary and family members, psychologists, psychiatrists, and other stakeholders. The purpose of this committee is to determine the compliance review team's scope by deciding which objectives will be examined during the review. Focus group results of the prior year reviews help the committee narrow down specific objectives, which are set forth in DMH's Annual Review Protocol For Consolidated Specialty Mental Health Services.

The compliance review team conducts its annual review based on recommendations of the Compliance Advisory Committee.[29] Although the review protocol is applied uniformly at each MHP, reviews are subject to interpretive subjectivity by individual reviewers. Any deficiencies identified during the review are reported to the MHP and to the TAT Unit.

In accordance with the implementation of the MHP, the TAT also oversees the following activities in cooperation with other collaborating units within DMH:

- Quality improvement work plans
- Cultural competency plans
- Grievance logs
- Therapeutic behavioral services
- Plans of corrections
- Specialized reviews and contract monitoring
- State fair hearings
- Focused reviews
- Implementation plan approvals

Quality improvement processes vary greatly among MHPs. The evaluation process may include a medical record and facility review of the provider's office location(s) including a chart audit of approximately 10 percent of active Medi-Cal beneficiaries. The medical record review may include any of the following: chart organization, preventive health, or coordination/continuity of care. The facility review includes safety, physical accessibility, physical appearance, adequacy of waiting and examining room space, maintenance of confidentiality, and availability of appointments. Postings of culturally competent literature regarding patients' rights, the grievance process, and beneficiary information are also investigated.

[29] The results of the annual compliance review for 8 sample counties are summarized in Appendix 2.

The chart review of beneficiary records can either be a clinical examination or a review of non-clinical attributes, depending on the MHP's objectives. DMH provided general standards for beneficiary records and it is the MHP's responsibility to ensure that records comply with standards. Charts are reviewed to determine whether required documentation, such as assessments, client plans, and progress notes includes the following:

- Proper authorization from the appropriate disciplines
- Consent obtained from beneficiaries
- Medication prescriptions and reactions
- A diagnosis consistent with the client plan and progress notes
- The beneficiary's presenting problems, history, and current support system
- The beneficiary's specific goals, strengths, and stressors

If the chart review reveals that provisions have not been met, a written exception may be communicated to the provider requiring corrective action. Follow-up is conducted by the MHP to ensure that all necessary changes were made. Non-compliance could result in disallowance of payment or suspension from plan participation.

Some MHPs implement more sophisticated systems than others, due to resource availability and organizational structure. Larger MHPs may have numerous committees, including ad-hoc policy review committees that meet as necessary and work closely with other units, such as research and evaluation units, to collect, analyze and generate data on beneficiary and provider satisfaction, utilization, penetration rates, and other managed care trends faced by the MHP. This data can be instrumental in rating the beneficiaries' responsiveness to service availability, and in identifying problems and inefficiencies in specific programs or services.

Smaller counties may be able to meet on a more frequent basis, retain tighter control over authorization for treatment services and medication, and create additional levels of communication. However, they may be less able to devote staff time to important data analysis that may allow identification of improvements and changes based on actual performance outcome data. Smaller MHPs recognize this impediment and are working towards dedication of staff to perform this data analysis function. Unfortunately, some MHPs will need to commit significant resources to upgrade antiquated management information systems (MIS) in order to more effectively monitor and measure quality.

Areas of Concern

Consolidation was intended to promote the consistent statewide provision of specialty mental health services. However, DMH understands that geographical and demographical differences among California's counties require flexibility and creativity in implementing service delivery programs. As such, DMH allows MHPs the flexibility to develop and implement programs to best meet their resource and clientele needs, so long as counties comply with their DMH contract, their Implementation Plans, and applicable laws and regulations.

The flexibility granted to MHPs to design unique mental health service delivery programs allows a wide latitude that all but guarantees statewide diversity. Additionally, certain funding arrangements made at the state level may provide for inconsistencies in service delivery across California. These inconsistencies often have an impact on quality. We identified the following statewide issues that could affect quality:

- Barriers to overall coordinated care include the disconnect between county-operated/contracted and network fee-for-service providers, the inconsistent sharing of treatment results among providers, and the inconsistent provision of case management to mental health beneficiaries.
- MHPs are not at risk for cost of medications.
- Inconsistent statewide ability to discharge beneficiaries to lower levels of care possibly resulting in increased hospital administrative days and inpatient recidivism rates.
- Inconsistent statewide scope of quality management systems, especially pertaining to provider chart reviews.
- Lack of a special incident reporting system for outpatient services.
- Inconsistent statewide methodologies and periodicity requirements for preparation and update of assessments and client plans.

Barriers to Overall Coordinated Care

Although visited MHPs appeared to provide at least some level of coordinated care, provision methods vary and current coordination levels are inconsistent. County staff also expressed a lack of direction from DMH as to specific guidelines for implementation of certain operational procedures. Some potential obstacles to effective coordinated care are:

- Disconnect between county-operated/contracted and network fee-for-service providers.
- Treatment results are inconsistently shared among providers.
- MHPs inconsistently provide case management to mental health beneficiaries.

County staff cited human and fiscal resource issues as possible explanations for these perceived conditions. The nature and extent of these resource issues varies by county. It is possible that some counties may be able to provide higher levels of coordinated care than others. For instance, coordinated care may be easier for smaller counties, due to smaller beneficiary populations, fewer providers, and closer geographic proximity between providers. For example, we observed that one small rural MHP, with a provider network of less than ten facilities located within ten miles of each other, used a single chart to document treatment delivered by all providers, with the exception of the inpatient hospital. Beneficiaries in this county receive a higher level of coordinated care than beneficiaries in counties where this practice is not employed.

The first perceived obstacle that we observed to coordinated care was the statewide disconnect between county-operated/contracted and network fee-for-service providers. The SMHSC waiver program combined county-operated, contracted, and network fee-for-service providers from FFS/MC and SD/MC, putting them under the administrative control of MHPs, in an effort to expand access and consolidate the two funding streams. However, while access to both provider bases has expanded through this consolidation,[30] MHPs still view fee-for-service providers as separate and distinct from county-operated and contracted facilities. Our visits to ten MHPs provided the following examples:

- Initial referral to network fee-for-service providers may be limited to lower-end beneficiaries, while higher-end beneficiaries are initially referred to either county-operated or contracted providers.
- Beneficiaries initially referred to network fee-for-service providers may not be considered a part of the county's system of care.

[30] See the Evaluation of Access Chapter.

- County databases infrequently include information about all providers. Specifically, most MIS databases used to identify providers treating MHP beneficiaries include only

- county-operated and contracted providers. They do not usually include network fee-for-service providers.
- MHPs typically impose less stringent operational and/or charting requirements on network fee-for-service providers than they do on county-operated or contracted providers. Specifically, while county-operated and contracted providers are usually required to use certain forms and to follow certain organizational/content guidelines for beneficiary charts, network fee-for-service providers are given discretionary control over form design and usage, and chart organization and content. As a result, MHP staff indicated there is no chart consistency or predictability among network fee-for-service providers.
- Network fee-for-service providers are subject to less comprehensive quality assurance and chart reviews than are county-operated and contracted providers. Additionally, although such reviews are done fairly routinely at county-operated and contracted providers, they are rarely performed at network fee-for-service providers.
- Despite consolidation, county-operated and contracted providers still operate on reimbursements under SD/MC, while network fee-for-service providers still operate on reimbursements under FFS/MC.
- Although counties typically require county-operated and contracted providers to have progress notes to support billings, MHPs inconsistently require network fee-for-service providers to submit support for billed amounts. Network fee-for-service provider billings are rarely reviewed for supporting documentation.

We recognize the tendency to view network fee-for-service providers as distinct and different from county-operated and contracted providers. We also realize, however, that for a system of care to be truly consolidated, lines of distinction should not be as prominent as they were prior to the SMHSC waiver program. The decision to incorporate network fee-for-service providers into the county system of care must be made by MHPs, after consideration of the consequences of continuing to operate a bifurcated system of care.

A second possible barrier to coordinated care is the inconsistent sharing of treatment results among providers. Although MHPs have differing policies regarding centralized review of treatment results from concurrent providers, counties generally do not provide for such a review. Instead, MHP representatives usually stated that case managers, service coordinators, or treating clinicians are responsible for coordination through communication. Despite this unofficial policy, counties do not appear to have implemented policies to require county-operated, contracted, or network fee-for-service providers to share either beneficiary charts or documented treatment results.

Confidentiality, security, and inconvenience are some likely reasons why beneficiary charts are seldom physically shared between providers. These may also be explanations for the usual lack of sharing of treatment results (usually documented in progress notes) between providers. We did observe, however, that although providers do not seem to share progress notes (copies of progress notes from one provider are not documented in the chart of another provider), some providers document communication with other providers. As expected, chart documentation of cross-provider communication is better in some counties than in others.

As a partial offset to this condition, quality assurance committees in some counties perform concurrent chart reviews at all providers. Although committee chart reviews are usually compliance-oriented, reviewers sometimes check for documented evidence of communication

between providers. However, these concurrent reviews of provider charts do not occur in all counties. Additionally, chart reviews usually occur annually for only a small percentage (between 5 percent and 10 percent) of total beneficiary population. As such, this infrequent policy does not ameliorate the effects of the lack of centralized review.

It should be noted that the lack of centralized review mainly affects beneficiaries receiving concurrent services from multiple providers. Beneficiaries treated by a single provider automatically receive centralized review because their treatment results are documented in a single chart at that particular provider. While we recognize that centralized review of all treatment results for all beneficiaries in every county may be a resource-intensive undertaking, we also understand that truly coordinated care depends on a determination that services provided at all locations is complete, non-duplicative, and responsive to the needs of each beneficiary.

A third potential hindrance to coordinated care is the inconsistent provision of case management services to mental health beneficiaries. The Welfare and Institutions Code (WIC) states that case management should be part of the "minimum array of services" available to children, youth, adults, and older adults to the extent resources are available.[31] WIC defines case management as "beneficiary-specific services that assist beneficiaries in gaining access to needed medical, social, educational, and other services."[32] Some of these services might include:

- Identify and facilitate goals and objectives to enhance beneficiary's well being.
- Develop and maintain a consistent relationship with the beneficiary.
- Communicate effectively with the beneficiary and beneficiary's family.
- Exercise professional judgment to prepare client plans that address beneficiary impairment(s) in a positive manner.
- Acquire knowledge of available resources and programs.
- Act as an advocate for the beneficiary.
- Proactively identify and address beneficiary needs.
- Evaluate and document beneficiary status and progress.

Although all ten counties visited provided case management services in different ways and to various extents, most counties have not developed a standard by which case managers will be assigned. Specifically, although some counties are able to provide a case manager for every beneficiary, due to an insufficient number of case managers, not every beneficiary in every county can be assigned to a case manager. Beneficiaries are approved for case management services based on impairment, need, and availability of provider staff. Beneficiaries not assigned a case manager may receive case management type services from other staff including their clinicians, a service coordinator (discussed below), or other staff involved in their treatment.

Although the scope of case management services varies by MHP, it tends to be non-clinical in nature and does not extend to a centralized review of treatment results from all providers. Case managers and staff providing case management services usually address the more social aspects of treatment, including financial, housing, interpersonal, and other basic needs. They are primarily charged with ensuring that beneficiaries receive "360-degree"[33] care. They may

[31] WIC, Sections 5600.5, 5600.6, and 5600.7.
[32] WIC, Section 5600.4(e).
[33] A term used by staff in several visited MHPs to indicate that all beneficiary needs (both clinical and social) are considered.

also communicate with other providers treating their beneficiaries, although we did not observe prevalent documentation of this communication in charts.

Service coordinators are another means counties employ to provide care coordination. In some counties, service coordinators are synonymous with case managers. Several counties assign these individuals to beneficiaries at either the beneficiary's primary provider facility or at all facilities at which the beneficiary is being treated. When multiple coordinators are assigned, the individual assigned at the beneficiary's primary treatment facility becomes the primary coordinator. Coordinators are responsible to communicate with their counterparts at other provider facilities.

Although centralized review of treatment results is not a typical duty of case managers, service coordinators, or staff providing case management services, service is enhanced by the fact that some oversight and coordination between clinical and social needs is provided.

Perceived differences between county-operated, contracted, and network fee-for-service providers, lack of centralized review of treatment results, and inconsistent case management philosophies potentially hamper counties' ability to provide coordinated care. However, it is important to recognize that despite these continuing challenges, the SMHSC waiver program has increased the opportunity for better coordination by consolidating administrative oversight responsibility within the counties.

MHPs are Not at Risk for the Cost of Medications

Modern views hold that an individual's state of mental health can be affected by many factors, including genetic inheritance, external stressors, and internal chemical imbalances. Common treatments for mental illness used to include demobilization, tranquilization, and lobotomies. Technological advances have made available more civilized methods of professional treatment for mental illness, such as psychotherapy and medications.

Although medications often relieve the symptoms of mental illness and allow individuals to more effectively participate in prescribed psychotherapy, they almost invariably have side effects. As such, scrupulous evaluation and monitoring is required in all instances where medications are prescribed.

At the county level, primary authorization and monitoring responsibility is given to the prescribing psychiatrist. MHPs inconsistently provide for various levels of secondary review, such as medication monitoring by registered or licensed vocational nurses and prescription reviews on a sample basis by a pharmacist.

There are many views on the issue of medication prescribed in the treatment of mental illness. Understandably, such diverse groups as beneficiaries, providers, and advocates hold different perspectives. Added to these divergent viewpoints is the fiscal fact that MHPs are not responsible for the cost of medications.

Mental health researchers and professionals believe that many diagnosed mental illnesses can be ameliorated or treated with psychiatric medication, either solely or in conjunction with psychotherapy. Although medication can be viewed as an integral part of any treatment plan, it can also be seen as a convenient remedy prescribed in lieu of more therapeutic psychotherapy.

Generally speaking, provision of psychotherapy is more time-intensive than prescription and monitoring of medications. Psychiatrists, often seen as appropriate providers of psychotherapy, are also the only professionals able to prescribe psychiatric medications. As discussed in the

Evaluation of Access Chapter, psychiatrists are in short supply and their numbers are not increasing at the same rate as the mentally ill population. MHPs are forced to consider economics in response to increasing demands on their limited number of psychiatrists. MHPs are generally not equipped with enough psychiatrists to provide both therapeutic psychotherapy and medication prescriptions to all beneficiaries. Psychiatrists must be involved in the prescription of psychiatric medication, either directly or in a supervisory capacity. MHPs must choose between providing psychotherapy to selected beneficiaries and prescription of medications to more beneficiaries.

Many MHPs choose to limit treatment involvement of psychiatrists to evaluations and prescription of medications. Some county representatives indicated that psychiatrists are too valuable to use for psychotherapy, when larger populations could be served by having them prescribe medications. Psychiatrists on the other hand, may want more involvement in treatment than prescription of medications. This could be a Catch 22 situation, because psychiatrists may not come to MHPs if their involvement is limited to purveying drugs, and counties may not be able to expand responsibilities if they don't have enough psychiatrists.

The fiscal aspect of this stress on psychiatrist usage cannot be overstated. Consolidation was intended to "better utilize existing resources at both the state and local levels to improve the effectiveness of necessary mental health services."[34] Although counties are legally responsible to provide mental health treatment to residents, they are not financially liable for the costs of all forms of treatment. Currently, Medi-Cal fully absorbs the cost of medications issued to beneficiaries by MHPs.

At first glance, this arrangement would appear to reflect an imbalance in the concept of shared risk for medication costs between the State and county MHPs. Specifically, because many county representatives feel resources may be insufficient to identify and serve all needs, there is a concern that MHPs may choose to prescribe medications as a means to conserve their own scarce resources. This could lead to uneven access to clinical interventions and medications across California, and could potentially affect quality of treatment.

On the other hand, arguments can be made to suggest that the State should retain full responsibility for the cost of medication. Specifically, if MHPs share the cost of medications, they would also be affected by the rise or fall in medication prices. Escalations in costs could cause less affluent counties to delay or discontinue the use of certain psychiatric medications. The resulting potential disparity between statewide access to services and medications may also have an effect on quality of treatment. Because the State has greater financial resources and wields more statutory authority than do MHPs, the State may be the appropriate body to incur costs of medications to help ensure equitable statewide levels of access to various medications. If MHPs do not have to consider how increases in medication costs affect resources available for other forms of treatment, they can better ensure provision of appropriate treatment.

This situation could be amplified by the general lack of medication oversight, both at the state and local levels. Specifically, while the SMHSC waiver program granted a great deal of administrative responsibility to counties to promote more effective use of local resources, we observed a lack of uniformity in medication monitoring at the local level.[35] In addition, neither DMH nor DHS appears to monitor statewide pharmacy utilization rates. Without statewide monitoring of medication utilization trends, it would be difficult to identify and analyze unusual fluctuations in an effort to promote appropriate use of resources and provision of services.

[34] WIC, Section 5600.
[35] Refer to the Chart Review Chapter for statewide observations.

Certainly, the prescription of medications helps many people suffering from mental illness return to and maintain a stable living environment. As technology advances, new techniques may decrease the effects of a number of illnesses that severely impair normal functioning. As society turns to technology for more solutions, it could become very easy to depend almost completely on medical science. To help mentally ill beneficiaries receive the most appropriate treatment, it is important to guard against potential over-reliance on medication and to ensure that other forms of treatment are not overlooked.

As discussed earlier, Medi-Cal bears the cost of these medications. Yet, despite the fact that the State has fiscal responsibility, neither DMH nor DHS monitors pharmacy utilization rates among the various MHPs. There could be a number of reasons for fluctuations in pharmacy utilization trends. For instance, the ever-burgeoning population requiring specialty mental health services could cause an upward trend in utilization rates. On the other hand, the statewide move towards the Rehab Option could have the opposite effect.

Without tracking usage trends, it would be difficult to establish a baseline norm. Consequently, the State may find it arduous to accurately predict future usage levels and to budget accordingly. Lack of MHP-specific data could also hamper the State's ability to timely identify and research unexpected trends and fluctuations.

Inability to Discharge Beneficiaries to Lower Levels of Care

One goal of managed care was to minimize inpatient dollars and increase outpatient dollars, while reducing the number of admissions and length of stay, without adversely affecting quality. As discussed in the Evaluation of Access Chapter, the shortage of step-down facilities impairs the ability of MHPs to find appropriate placements for beneficiaries, particularly those that are difficult to place. Economic issues, geographic locations, and IMD exclusion delays often prevent beneficiaries from being discharged to more suitable levels of care in a reasonable amount of time. This results in an increase in both acute-level administrative days and recidivism rates.

As illustrated in Table 3, although different regions throughout California experience either a decrease or increase in the number of administrative days from year to year, overall the numbers are slowly rising. This could be a result of closures or mergers of mental health care facilities, the unpredictable economy, and various external factors. With hospital stays being the most expensive treatment resource, the lack of placement alternatives could imply that some beneficiaries are receiving sub-standard quality services at a costly price. Extended stays in inappropriate settings could be detrimental to beneficiaries' recovery and may cause beneficiaries to be under the MHP's care for a longer period of time. This widespread problem not only affects quality of services, but it is probably not considered the most cost-effective use of resources.

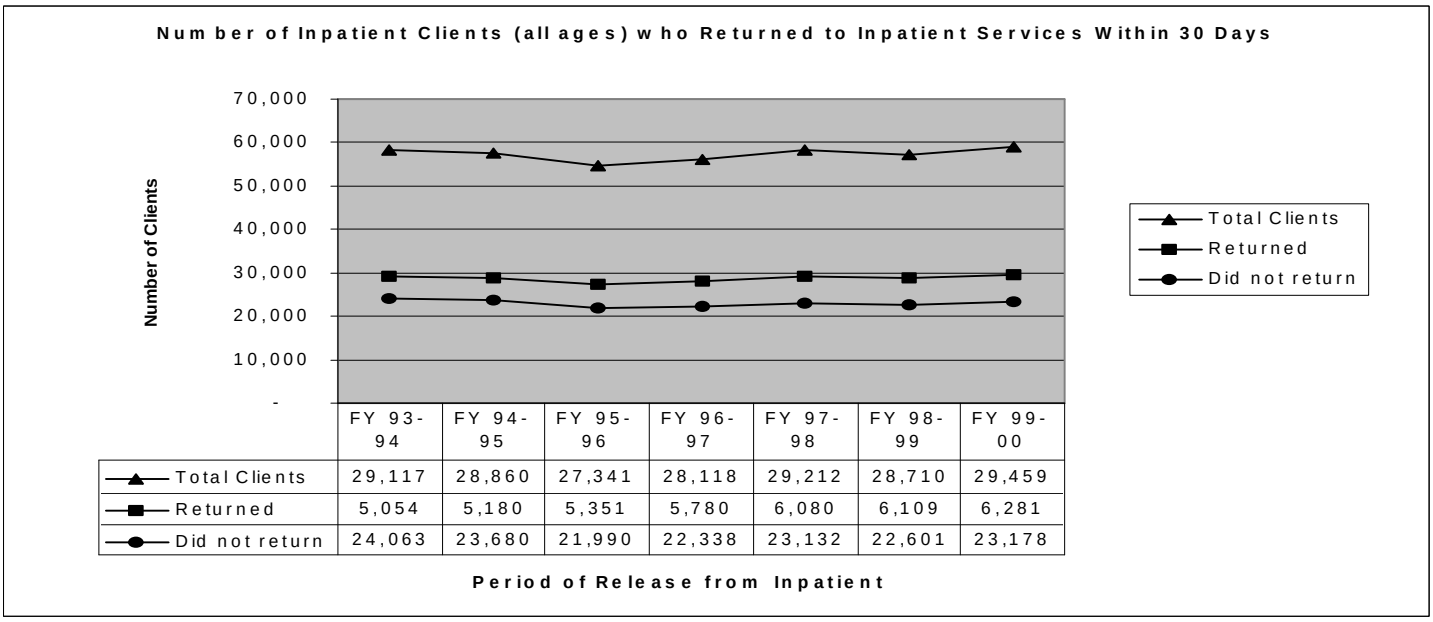
Table 3—Administrative Days by Region[36]

Administrative Days by Calendar Year by Region	1998	1999	2000
Bay Area Region	17,157	17,141	17,644
Central Region	631	835	614
Los Angeles Region	5,394	10,241	13,812
Southern Region	12,860	15,602	14,755
Superior Region	484	413	726
Total	36,526	44,232	47,551
% Increase from year to year	N/A	21.1%	7.50%

Another potential effect of improper beneficiary placements is the increase in recidivism. DMH data shows that a large number of beneficiaries discharged from inpatient services receive one of the following types of services within zero to seven days: linkage, medication, mental health, day treatment, residential, crisis, and inpatient. Although strides have been made to link beneficiaries to services after hospital discharge, many beneficiaries fall through the cracks, go through the "revolving door," and require re-admission for inpatient care. Table 4 shows that within 30 days after discharge, re-admission rates have slightly increased since 1993-94.

[36] DMH, Statistics and Data Analysis Unit. Data reflects mental health SD/MC hospital inpatient consolidation data as of August 1, 2001 for all age groups.

Table 4—Readmission Rates[37]



	FY 93-94	FY 94-95	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00
Total Clients	29,117	28,860	27,341	28,118	29,212	28,710	29,459
Returned	5,054	5,180	5,351	5,780	6,080	6,109	6,281
Did not return	24,063	23,680	21,990	22,338	23,132	22,601	23,178

Because of fiscal and programmatic impacts on MHP operations, preliminary studies have been conducted to assess the reasons for such trends. The State Quality Improvement Committee created the Inpatient Treatment Review Workgroup to investigate possible reasons for the trends. One MHP analyzed trends in re-admission rates and their effects on bed utilization and acute inpatient costs since the beginning of managed care in 1995 through 2000-01. The study was initiated when MHP representatives discovered that seven beneficiaries were hospitalized six or more times during 2000-01, and collectively utilized more than $250,000 in acute psychiatric inpatient hospital services. Significant outcomes from the study include:[38]

- Since 1995, a three-fold increase in the number of Medi-Cal beneficiaries who were admitted three or more times within a year.
- For beneficiaries with multiple hospitalizations in a year, the average length of stay increased about 50 percent, from nine days in 1995-96 to over thirteen days in 2000-01.
- The average number of days between hospital re-admissions is about 42 days.

Some clinicians may argue that re-hospitalization should not necessarily be frowned upon. Beneficiaries and case managers may view extended hospital stays (while waiting for lower-level placement) as more detrimental than returning to the community and later readmitting to the hospital, as necessary.

Although DMH data illustrates efforts made to link beneficiaries to services after hospital discharge, other factors may affect the situation, including the lack of intensive case management, failure to ensure beneficiaries are timely linked to appropriate outpatient services, and shortage of placement alternatives.

[37] Department of Mental Health handout at the January 9, 2002 Quality Improvement Committee meeting.
[38] Survey conducted at Orange County in October 2001 "Re-admission Trends in Inpatient Services."

Inconsistent Statewide Scope of Quality Management Systems

As previously discussed, Title 9 requires MHPs to establish a quality management program containing certain elements. Each MHP is responsible to design and implement its own system of quality management (QM). Consequently, the scope and extent of these systems can vary greatly by county. One aspect of the QM system particularly subject to disparity is chart reviews. In response to Title 9 and contract requirements, most counties provide for chart reviews as part of their QM function. Each county has unique geographic and resource issues with which it must contend and, as a result, chart review protocols and procedures can be quite different at each MHP. Typically, chart reviews are performed annually of between 5 percent and 10 percent of beneficiaries active in the county system, although at least one large, urban county performs no regular chart reviews.[39] Chart reviews are usually limited to county-operated and contracted providers; it is rare for MHPs to perform these reviews at network fee-for-service providers. Counties also inconsistently review submitted claims for supporting documentation and inconsistently require providers to perform their own internal quality management chart reviews.

Because each MHP's quality management system is autonomous and the quantitative data collected is county-specific, it is difficult to generate aggregate results that can be used for comparability analyses and overall performance reports. Federal and state QM regulations are flexible to allow MHPs to tailor systems to meet the needs of their populations. Additional guidance in this area would help MHPs function as efficiently and effectively as possible.

Given their different needs, MHP information and data collection systems vary in sophistication and capacity. Typically, larger counties featured more specialized information systems capable of processing billing and tracking beneficiary data for more complex populations. Conversely, smaller counties with less taxing demands on their system tend to employ less sophisticated technology. Additionally, few visited counties operated with what they considered "state-of-the-art" equipment. In many cases, the systems were substantially dated. Many MHPs intend to renovate or upgrade their systems to resolve self-identified system inadequacies.

The lack of uniformity in the quality and capacity of these information and data collection systems directly impacts monitoring functions required under the SMHSC waiver program. In particular, varied levels of inherent system quality and capability put certain access and quality monitoring functions out of reach for some MHPs. This hampers DMH's intent to bring statewide uniformity to the monitoring function. Aside from impeding uniformity, antiquated systems prevent MHPs from developing an accurate picture of beneficiary populations and service effectiveness.

Lack of a State Special Incident Reporting System

Counties are not required to submit outpatient mental health incidents. DMH, however, does review a sample of these reports during the annual contract renewal period. Special incident reporting requirements are included in performance contracts and in the MHP or managed care contracts. This process is consistent with current California law and federal requirements.

Although MHPs have an established special incident reporting system for inpatient care, DMH does not monitor special incidents for outpatient care. Periodic reviews of these documents during the annual compliance review could enhance DMH's current special incident reporting

[39] This MHP performs exception reviews of county-operated and contracted provider charts, but does not review network fee-for-service provider charts. This county does require county-operated and contracted providers to self-assess charts. MHP staff may periodically verify information provided in self-assessments.

system and help DMH ensure that special incidents are timely and properly addressed. This information could also be useful to the TAT Unit for training purposes and to Quality Improvement Coordinators for trend analyses.

Inconsistent Preparation and Update of Assessments and Client Plans

Assessments and client plans are crucial components of mental health service delivery. Although WIC requires assessments and plans be offered as part of MHP's array of treatment options,[40] it does not appear that there is specific regulatory guidance for assessment or client plan preparation. Such direction could include a description of the appropriate preparer, content, timeframes, and update frequency and methodology.

Preparer

Neither current laws and regulations, nor the standard DMH contract specifically direct who should be responsible for performing client assessments or client plans. Although DMH views this as a scope of practice issue and allows MHP administrators to match professional responsibilities with duties permitted by licensing boards, DMH supports counties' adherence to provisions of the Rehab Option Manual (used prior to consolidation) concerning this issue. Specifically, the Manual stated that persons qualified to perform assessments and prepare client plans were Licensed Practitioners of the Healing Arts (LPHA). Professionals in this category include, but are not limited to, psychiatrists, psychologists, licensed clinical social workers (LCSW), and marriage and family therapists (MFT). Non-LPHA staff may also perform these duties under LPHA supervision.

This may cause concern because the LPHA review and sign-off could be perceived as a rubber-stamp function, particularly in light of human resource shortages, which may prompt MHPs to use non-LPHA staff. If LPHAs are not available to conduct assessments and prepare client plans, their level of involvement in work conducted by subordinate staff may be questioned. This could have a direct effect on perceived quality of services, particularly if services are not delivered by mental health specialists as required by Title 9.[41]

Although the DMH contract is silent as to who should prepare assessments, it does require that client plans be signed or approved by a physician, a registered nurse, or a licensed/registered/ waivered professional (implying that plans should be prepared by this person).[42] We observed the following issues with respect to assessment and plan preparers in visited MHPs:

- Counties tend to use LPHAs to either prepare or supervise staff preparing assessments and client plans.
- Assessments and plans are typically prepared by the same MHP staff member. When beneficiaries require more than one type of service (e.g., medication and psychotherapy), each treating clinician may prepare a separate assessment and plan.
- Assessments and plans are prepared by either a single person, or multidisciplinary team comprised of various levels of professional staff.

[40] WIC Section 5600.4.
[41] CCR, Title 9, Chapter 11, defines a provider of mental health services as a "person or entity who is licensed, certified, or otherwise recognized or authorized under State law governing the healing arts to provide specialty mental health services . . ."
[42] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C.

Content

Although current laws and regulations neither require the statewide use of standardized forms nor specifically set forth what elements assessments or client plans should include, the DMH contract provides limited guidance as follows:[43]

- Assessments should address certain areas, including the beneficiary's relevant physical health conditions, presenting problems, strengths in achieving plan goals, special situations, medication information, allergies, mental health history, developmental history, past/present use of prescribed and over-the-counter drugs, mental status examination, and diagnosis.
- Client plans should have specific observable and/or specific quantifiable goals; identify the proposed type(s) of intervention; be consistent with the diagnoses; and include documentation of beneficiary participation in and agreement with the plan (e.g., beneficiary signature or description of beneficiary involvement).

Within each MHP, county-operated and contracted providers are usually required to use standardized assessment and client plan forms. Network fee-for-service providers are typically given flexibility to design and use their own forms. Although some forms are naturally more detailed than others, we observed that assessments and plans generally conform to requirements of the DMH contract, except that beneficiary strengths in achieving plan goals were more commonly included in client plans. We observed the following traits at visited MHPs:

- Some MHPs require separate assessments and plans by each professional delivering service within a provider facility. Specifically, one county may provide for a separate assessment and client plan by a case manager, a clinician, and a psychiatrist for beneficiaries authorized for case management, psychotherapy, and medications, while another MHP may use an all-inclusive clinical assessment and client plan. Most visited counties used the all-inclusive format.
- Many MHPs require a separate psychiatric evaluation when medications are prescribed. In some counties, a psychiatric evaluation can also serve as a clinical assessment.
- "Brief assessments," prepared at intake by an access team (or team member), are inconsistently used throughout California. When used, brief assessments are typically followed by a comprehensive clinical assessment.
- Several counties require separate assessments by each provider facility, although some permit sharing of assessments to avoid duplication of efforts. The decision to rely on a previously prepared assessment is usually left to the discretion of individual providers.
- Although most assessment forms included a diagnosis section, some MHPs document diagnoses separately.
- Although assessments generally include an evaluation of both the clinical and the social aspects of beneficiary impairments, client plan interventions tend to be limited to amelioration of a beneficiary's clinical symptoms. Although case managers, when assigned, may address the beneficiary's more social needs, there are infrequent requirements for a separate client plan to document planned social interventions (usually in the progress notes).
- Some counties do not require client plans for beneficiaries whose only planned intervention is medication or case management.

[43] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C.

- Some counties use client plan forms with pre-listed service goals, interventions, or both. Specifically, preparing clinicians select a goal(s) and/or intervention(s) for their beneficiary from a list of several possible objectives and treatment interventions.
- Assessments and client plans mention medical necessity inconsistently and infrequently.
- Assessments and client plans inconsistently include reference to cultural competence issues (i.e. document whether the beneficiary has specific language needs).
- Assessments and client plans inconsistently document planned family involvement.

Timeframes

There are no specific requirements, either regulatory or contractual, to set the point in the treatment process at which beneficiaries must be initially assessed. Neither are there requirements governing initial preparation of client plans. The DMH contract allows MHPs to establish timeliness standards for assessments and client plans.[44] This flexibility naturally resulted in counties requiring these services at different times. Observed timeframes typically ranged from two to four months from entry to the system. This means beneficiaries in visited MHPs could be in the system for up to four months before their formal assessments and client plans are prepared.

Update Frequency and Methodology

Neither regulatory nor contractual requirements specifically define rules for assessment or client plan periodicity. Although the DMH contract allows MHPs to establish frequency standards for assessment updates, the contract requires client plans to be updated at least annually, though MHPs can require more frequent update.[45] Naturally, this discretionary control has resulted in divergent statewide procedures for assessment and plan updates. Specifically:

- Some counties had no requirement that assessments be updated, while others required formal updates at various intervals ranging from twice a year to every three years. Assessment updates are usually independent of updates to other documents; i.e., they are usually not triggered by changes to either diagnoses or client plans. It should be noted that although formal updates may not be required in all counties, clinicians tend to perform on-the-spot client assessments at each visit as a matter of practice. Clinician contacts with beneficiaries are documented in the progress notes. Thus, it is arguable that client status assessments are conducted periodically, as part of continuing treatment.
- Nearly all visited MHPs require updates at least annually, although many provide for more frequent update at various intervals ranging from three to six months, depending on beneficiary need. One MHP did not state a minimum requirement of annual updates, but instead required that plans be updated as required or as they expired (it seemed plan durations did not extend beyond one year). MHP representatives stated that plan frequency is based on subjective evaluations of “appropriateness.”

In conclusion, assessments and client plans are integral components of effective treatment. While statewide guidance for both is limited, more direction is provided for client plans than for assessments. If processes for impairment assessment and intervention planning are not consistently applied by MHPs, the SMHSC waiver program’s ability to provide statewide comparable services could be significantly affected.

[44] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C.
[45] Ibid.

Conclusion/Recommendations

Overall, we concluded that the quality of services has improved. Although we acknowledge that the SMHSC waiver program's many strengths led to our overall conclusion, we also recognize the need for improvement in this still-evolving program. While we can provide general recommendations for some of the statewide inconsistencies, risk areas, and other issues identified in this section, many require consideration and analysis by DMH to determine the most appropriate course of action. We make the following recommendations:

- Develop statewide guidelines and best practices to provide guidance and assistance so that MHPs can operate at the optimal level. Develop a State Quality Improvement Plan to coordinate oversight efforts and support MHPs.
- Enhance the existing special incident reporting system to include reportings on inpatient care. Revise the annual compliance review protocol to include a review of such reportings.
- Implement a plan for monitoring medication utilization trends in order to identify unusual fluctuations and promote appropriate use of resources.

PERFORMANCE OUTCOME DATA ANALYSIS

Introduction

California's current performance outcome system was developed, in part, because of the Bronzan-McCorquodale Act of 1991. Prior to this Act, collecting performance outcome and consumer satisfaction data was left to the discretion of local mental health programs. The Bronzan-McCorquodale Act promoted statewide uniformity by creating a centralized process whereby all local mental health programs would be required to use standardized instruments for data collection.

To create the performance outcome system, the Department of Mental Health director was charged with the responsibility of establishing a performance outcome committee. From this requirement, the Performance Outcome Advisory Group (POAG) was formed. The POAG consisted of members from the Department of Mental Health (DMH), the California Mental Health Directors Associations (CMHDA), the California Mental Health Planning Council (CMHPC), clients, family members, and mental health advocate groups.

POAG's mission was to develop performance outcome measures to gauge the quality and cost-effectiveness of California's county mental health departments. This is primarily accomplished through the collection of performance data using various outcome instruments. These instruments were developed to generate information to:[46]

- Assist clinicians with treatment planning and service provisions.
- Affect quality improvement in local mental health programs.
- Provide performance outcome data to the State and Legislature.
- Provide comparative data illustrating the differences between California's public mental health programs and those of other states.

Child and Youth Performance Outcome System

The result of the POAG's efforts was the creation of a performance outcome system that is separated into three target groups. The first target group consists of a population of seriously emotionally disturbed (SED) youth who are less than 18 years of age, and who have or will receive mental health services for 60 days or longer. Clients who only receive medication services are excluded from this population. Exclusion is based on the assumption that these clients are generally stable. Therefore, including stable clients into a system designed to measure changes in a person's mental illness would skew the results. Performance outcome data for this group is gathered using instruments developed for the Children and Youth Performance Outcome System (CYPOS).

The CYPOS was fully implemented in April 1998. Counties are required to report to DMH their performance outcome results bi-annually. The CYPOS currently has seven performance

[46] Annual Report to the Fiscal and Policy Committee of the Legislature in Response to Chapter 89, Statutes of 1991 Assembly Bill 1288, WIC 5613.

instruments that counties use to collect this data, five of which require completion. The following are the required instruments:[47]

- Child Behavior Checklist (CBCL)
- Youth Self Report (YSR)
- Child and Adolescent Functional Assessment Scale (CAFAS)
- Client Satisfaction Questionnaire (CSQ-8)
- Client Living Environments Profile (CLEP)

The following instruments are recommended, but not required by DMH:

- Family Empowerment Scale (FES)
- Youth Satisfaction Questionnaire (YSQ)

Youth Survey Results

The following tables summarize statewide data from the five required performance outcome instruments for calendar years 1999 and 2000.[48] Tables present DMH's statewide survey results. We realize that these results include non-Medi-Cal beneficiaries; however, there are no survey results specific to the SMHSC waiver program.

Statewide CBCL Data

Table 5—CBCL Survey Results (1999)

1999 CBCL T-Scores	Intake (N=14,805)[49]	Mid-Treatment (N=6,080)	Discharge (N=1,834)
Total Competence Scale (Larger score = Greater Competence)	35.6	35.2	38.4
Total Problem Scale (Larger score = Greater Problem)	65.6	65.9	58.7
Total Internalizing Scale (Larger score = Greater Problem)	62.0	61.9	55.8
Total Externalizing Scale (Larger score = Greater Problem)	64.7	64.7	58.9

[47] Children/Youth Performance Outcome System Clinical Training Manual, California Department of Mental Health, January 10, 2001 version.
[48] Children and Youth Performance Outcome Data System Statewide Summary Data for 1999 and 2000 (http://www.dmh.cahwnet.gov/rpod/PDF/st-wide-sum-99-01.pdf).
[49] N is defined as the population.

Table 6—CBCL Survey Results (2000)

2000 CBCL T-Scores	Intake (N=15,398)	Mid-Treatment (N=7,023)	Discharge (N=1,778)
Total Competence Scale (Larger score = Greater Competence)	35.4	35.5	38.0
Total Problem Scale (Larger score = Greater Problem)	65.3	65.6	58.6
Total Internalizing Scale (Larger score = Greater Problem)	61.6	61.4	55.6
Total Externalizing Scale (Larger score = Greater Problem)	64.3	64.3	58.6

Statewide YSR Data

Table 7—YSR Survey Results (1999)

1999 YSR T-Scores	Intake (N=11,169)	Mid-Treatment (N=4,085)	Discharge (N=1,208)
Total Competence Scale (Larger score = Greater Competence)	40.2	41.0	42.2
Total Problem Scale (Larger score = Greater Problem)	57.7	57.5	53.3
Total Internalizing Scale (Larger score = Greater Problem)	56.1	55.6	51.5
Total Externalizing Scale (Larger score = Greater Problem)	58.2	58.0	55.4

Table 8—YSR Survey Results (2000)

2000 YSR T-Scores	Intake (N=9,021)	Mid-Treatment (N=4,341)	Discharge (N=994)
Total Competence Scale (Larger score = Greater Competence)	40.4	41.0	42.1
Total Problem Scale (Larger score = Greater Problem)	57.4	57.1	52.5
Total Internalizing Scale (Larger score = Greater Problem)	55.7	54.9	51.2
Total Externalizing Scale (Larger score = Greater Problem)	57.9	57.7	54.2

The CBCL and YSR scores place a client in one of three ranges: clinical, borderline clinical, and non-clinical. The ranges for the four scales follow:[50]

CBCL/YSR Scale Name	Scores in Clinical Range	Scores in Borderline Clinical Range	Scores in Non-Clinical Range
Competence Scale	<37	37-40	>40
Problem Scale	>63	60-63	<60
Internalizing Scale	>63	60-63	<60
Externalizing Scale	>63	60-63	<60

[50] Ibid.

Table 9—CAFAS Survey Results (Gender)

Gender	1999 (N = 46,218)	2000 (N = 35,989)
Males	46.5%	59.2%
Females	26.4%	34.8%
Unknown	27.1%	5.9%

Table 10—CAFAS Survey Results (Ethnicity)

Ethnicity	1999 (N = 46,218)	2000 (N = 35,989)
White	33.3%	44.3%
Spanish/Hispanic	20.0%	26.4%
African American	12.7%	14.0%
Asian Pacific	1.0%	1.6%
Native American	1.2%	1.5%
Southeast Asian	0.6%	0.9%
Filipino	0.4%	0.5%
Unknown	30.9%	10.8%

Table 11—CAFAS Survey Results (Age)

Age Categories	1999 (N=56,004)	2000 (N=42,315)
0 to 5	2.7%	3.4%
6 to 10	24.5%	30.0%
11 to 15	33.9%	43.1%
16 to 18	13.3%	17.5%
19 to 21	0.3%	0.7%
Unknown	25.4%	5.2%

Table 12—CAFAS Survey Results (Scale Scores for 1999)

1999 Statewide CAFAS Mean Scale Scores (Higher Score = Higher Impairment Level)	Intake (N=30,210)	Mid-Treatment (N=14,283)	Discharge (N=11,223)
Role Performance: School	17.5	16.7	13.8
Role Performance: Home	15.5	14.8	12.8
Role Performance: Community	7.6	6.8	6.4
Behavior Toward Others	14.7	14.1	11.8
Moods/Self-Harm: Moods/Emotions	15.1	14.5	12.3
Moods/Self-Harm: Self Harmful Behavior	7.9	6.7	6.6
Substance Abuse	3.9	3.0	3.9
Thinking	4.5	5.7	3.8
Total 5-Scale Score	55.5	52.8	41.7

Table 13—CAFAS Survey Results (Scale Scores for 2000)

2000 Statewide CAFAS Mean Scale Scores (Higher Score = Higher Impairment Level)	Intake (N=21,746)	Mid-Treatment (N=11,565)	Discharge (N=8,633)
Role Performance: School	16.9	16.3	11.9
Role Performance: Home	15.0	14.4	11.2
Role Performance: Community	7.9	6.7	5.7
Behavior Toward Others	14.2	13.8	10.1
Moods/Self-Harm: Moods/Emotions	14.8	14.1	10.2
Moods/Self-Harm: Self Harmful Behavior	5.3	4.6	2.5
Substance Abuse	4.5	3.0	3.5
Thinking	3.9	5.5	2.7
Total 5-Scale Score	54.0	51.3	38.3

CAFAS 4-level rating system follows:

30 = Severe Impairment (severe disruption or incapacitation)
20 = Moderate Impairment (occasional major disruption or frequent disruptions)
10 = Mild Impairment (significant problems and/or distress)
0 = Minimal or No Impairment (no disruption of functioning)

Statewide CSQ-8 Data

Table 14—CSQ-8 Survey Results

CSQ-8 Mean Scale Scores (Ratings: 1 = Low Satisfaction to 4 = High Satisfaction)	1999 (N=5,430)	2000 (N=16,414)
#1: How would you rate the quality of service you have received?	3.4	3.4
#2: Did you get the kind of service you wanted?	3.3	3.4
#3: To what extent has our program met your needs?	3.2	3.2
#4: If a friend were in need of similar help, would you recommend our program to him or her?	3.5	3.5
#5: How satisfied are you with the amount of help you have received?	3.3	3.3
#6: Have the services you received helped you to deal more effectively with your problems?	3.5	3.4
#7: In an overall, general sense, how satisfied are you with the service you have received?	3.4	3.3
#8: If you were to seek help again, would you come back to our program?	3.1	3.5

Statewide CLEP Data

Table 15—CLEP Survey Results (1999)

1999 Statewide Current Placement Setting	Intake (N=35,030)	Mid –Treatment (N=15,448)	Discharge (N=8,017)
Incarcerated (Prison, County Jail, CYA, Juvenile Hall, etc.)	4.9%	1.9%	2.8%
Psychiatric Hospital or Residential Treatment Center (Levels 13-14)	2.5%	2.5%	1.6%
Group Homes (Levels 1-12)	5.1%	4.4%	2.8%
Foster Care or Therapeutic Foster Care	11.2%	10.8%	8.0%
Living with Biological or Adoptive Family, Relatives, Friends, or Others in a Home Setting	73.9%	79.1%	80.6%
Living Independently by Self, with Spouse, Roommate, and/or Dependent Children	0.8%	0.5%	1.5%
Homeless	0.9%	0.3%	1.0%
Unknown	0.6%	0.6%	1.6%

Table 16—CLEP Survey Results (2000)

2000 Statewide Current Placement Setting	Intake (N=26,429)	Mid –Treatment (N=14,226)	Discharge (N=9,937)
Incarcerated (Prison, County Jail, CYA, Juvenile Hall, etc.)	3.5%	1.0%	3.5%
Psychiatric Hospital or Residential Treatment Center (Levels 13-14)	1.6%	2.6%	1.2%
Group Homes (Levels 1-12)	4.5%	5.5%	3.3%
Foster Care or Therapeutic Foster Care	9.8%	9.7%	8.3%
Living with Biological or Adoptive Family, Relatives, Friends, or Others in a Home Setting	79.1%	80.0%	80.0%
Living Independently by Self, with Spouse, Roommate, and/or Dependent Children	0.4%	0.4%	1.3%
Homeless	0.6%	0.3%	1.6%
Unknown	0.4%	0.5%	0.9%

Table 17—CLEP Survey Results (1999)

1999 Statewide Predominant Placement Setting	Intake (N=35,030)	Mid –Treatment (N=15,448)	Discharge (N=8,017)
Incarcerated (Prison, County Jail, CYA, Juvenile Hall, etc.)	1.0%	0.6%	2.3%
Psychiatric Hospital or Residential Treatment Center (Levels 13-14)	2.0%	2.2%	0.9%
Group Homes (Levels 1-12)	3.0%	3.8%	2.1%
Foster Care or Therapeutic Foster Care	8.9%	10.0%	7.9%
Living with Biological or Adoptive Family, Relatives, Friends, or Others in a Home Setting	66.3%	76.7%	77.1%
Living Independently by Self, with Spouse, Roommate, and/or Dependent Children	0.3%	0.4%	0.9%
Homeless	0.9%	0.3%	0.7%
Unknown	17.5%	5.9%	8.2%

Table 18—CLEP Survey Results (2000)

2000 Statewide Predominant Placement Setting	Intake (N=26,429)	Mid –Treatment (N=14,226)	Discharge (N=9,937)
Incarcerated (Prison, County Jail, CYA, Juvenile Hall, etc.)	1.3%	0.6%	2.4%
Psychiatric Hospital or Residential Treatment Center (Levels 13-14)	1.3%	2.4%	0.8%
Group Homes (Levels 1-12)	3.7%	5.2%	2.7%
Foster Care or Therapeutic Foster Care	8.9%	9.6%	8.8%
Living with Biological or Adoptive Family, Relatives, Friends, or Others in a Home Setting	81.6%	79.4%	79.8%
Living Independently by Self, with Spouse, Roommate, and/or Dependent Children	0.3%	0.3%	0.8%
Homeless	0.6%	0.3%	1.3%
Unknown	2.1%	2.2%	3.4%

Slight improvements can be seen in client functioning from 1999 to 2000. However, significant improvements in efficiency are shown in DMH's abilities to collect performance data. Specifically, decreases in the "unknown" category for the CLEP Predominant Placement Setting report and an increase in the number of CSQ-8 surveys completed from 1999 to 2000 are two examples of this increased efficiency.

Adult Performance Outcome System

The second target group consists of a population of adults with serious and persistent mental illness who are 18 through 59 years of age and who have or will receive mental health services for 60 days or longer. Similar to children, adults who receive medication-only services are excluded from this population. Performance outcome data for this group is gathered using instruments developed for the Adult Performance Outcome System (APOS).

The APOS was fully implemented in July 1999. Counties are required to report to DMH their performance outcome results bi-annually. The APOS currently has three performance instruments that the counties use to collect this data. The Mental Health Statistics Improvement

Program (MHSIP) instrument is one that is required by DMH.[51] Local mental health departments are given the option to select from one of the following required performance instruments:

- California Quality of Life (CA-QOL)
- Lehman's Quality of Life–Short Form (QL-SF)

The majority of counties prefer to use the CA-QOL in place of the QL-SF. As a result, DMH only has automated data for the CA-QOL at this time.

Adult Survey Results

The following tables summarize statewide data from the MHSIP and the CA-QOL performance outcome instruments for calendar years 2000 and 2001.[52] Tables present DMH's statewide survey results. We realize that these results include non-Medi-Cal beneficiaries; however, there are no survey results specific to the SMHSC waiver program.

Statewide MHSIP Data

Table 19—MHSIP 2000 & 2001 Survey Results

MHSIP Subscales	2000 (N=15,137)	2001 (N=19,860)
Access to Care	4.187	4.193
Appropriateness of Care	4.158	4.176
Perceived Outcomes	3.730	3.730
Satisfaction with Services	4.239	4.247

MHSIP ratings follow:

0 = Item does not apply.
1 = Client strongly disagrees with the item's statement.
2 = Client disagrees with the item's statement.
3 = Client feels neutral about the item's statement.
4 = Client agrees with the item's statement.
5 = Client strongly agrees with the item's statement.

[51] Adult Performance Outcome System Clinical Training Manual, Version 2; California Department of Mental Health, August 1999.
[52] California Quality of Life Survey Reports and Mental Health Statistics Improvement Program Consumer Survey Reports for 2000 & 2001.

CA-QOL

Table 20—CA-QOL 2000 & 2001 Subjective Survey Results

CA-QOL Subjective Scales	2000 (N=25,617)	2001 (N=28,358)
General Life Satisfaction	3.7575	3.7745
Satisfaction with:		
Living Situation	4.3365	4.3300
Leisure Activities	4.0130	3.9907
Daily Activities	3.9994	4.0083
Family Relationships	4.1616	4.1488
Social Relations	4.1492	4.1328
Finances	3.1268	3.1037
Safety	4.7216	4.7499
Health Status	3.7204	3.7067

CA-QOL Subjective Scales ratings follow:

1 = Terrible
2 = Unhappy
3 = Mostly Dissatisfied
4 = Mixed
5 = Mostly Satisfied
6 = Pleased
7 = Delighted

The CA-QOL identifies no significant changes in the clients' perception of quality of life satisfaction from 2000 to 2001. Clients continue to indicate that they have mixed feelings in this category.

Table 21—CA-QOL 2000 & 2001 Objective Survey Results

CA-QOL Objective Scales	2000 (N=25,617)	2001 (N=28,358)
Frequency of Family Contacts	3.2678	3.3265
Frequency of Social Contacts	2.9125	2.9505
Amount of Spending Money	2.4060	2.3988
Adequacy of Finances	0.6469	0.6242
Victim of Crime	0.0846	0.0913
Number of Arrest	0.0926	0.0885
Health Status	3.4182	3.4553

Overall, the clients indicated a higher rate of family and social contacts between the two years. Conversely, the clients indicated less spending money and less satisfaction with their finances. The clients also appear to be victims of crime more often but are arrested less often then prior years. In addition, the clients ranked their general health status slightly better in 2001 then in 2000.

The Objective Rating Scales are as follows:

Frequency of Family Contacts:
0 = No family
1 = Not at all
2 = Less than once a month
3 = At least once a month
4 = At least once a week
5 = Daily

Frequency of Social Contacts:
1 = Not at all
2 = Less than once a month
3 = At least once a month
4 = At least once a week
5 = Daily

Amount of Spending Money:
1 = Less than $25
2 = $25 - $50
3 = $51 - $75
4 = $76 - $100
5 = More than $100

Adequacy of Finances:
0 = No
1 = Yes

Victim of Crime:
0 = No
1 = Yes

Arrested:
0 = No arrests
1 = One arrest
2 = Two arrests
3 = Three arrests
4 = Four arrests
5 = Five arrests
6 = Six or more arrests

General Health Status:
1 = Excellent
2 = Very good
3 = Good
4 = Fair
5 = Poor

Older Adult Performance Outcome System

The third target group consists of a population of older adults with a serious and persistent mental illness who are 60 years of age and older and who have or will receive mental health services for 60 days or longer. As stated before, older adults who receive medication-only services are excluded from this population. Performance outcome data for this group will be gathered using instruments developed for the Older Adult Performance Outcome System (OAPOS).

Initially, older adults were assessed under the APOS performance instruments. Administrators felt the APOS instruments were not appropriate when assessing older adults. The general consensus was that older adults may find the APOS instruments difficult to complete and that the instruments did not center on improvements in functional areas that were appropriate for older adults.

The OAPOS is currently in the pilot testing stage. Eight counties were selected to test one or more of nine age-appropriate performance instruments. Two phases of data collection have been completed and the results are currently being analyzed by DMH. Once all data has been analyzed, DMH will select the performance instruments to be used for the OAPOS. The following performance instruments were selected by DMH for pilot testing:[53]

- Mini-Mental State Examination (MMSE)

[53] Performance Measure Results on California's Community Mental Health Performance Outcome Systems: Annual Report to the Fiscal and Policy Committee of the Legislature in Response to Chapter 89, Statutes of 1991 Assembly Bill 1288, WIC 5613; California Department of Mental Health, March 2001.

- Face Sheet
- Mental Health Statistics Improvement Program (MHSIP) Consumer Survey
- Brief Symptom Inventory (BSI)
- SF-12 Health Survey
- Activities of Daily Living (ADL)
- Instrumental Activities of Daily Living (IADL)
- OARS Social Support Subscale
- CAGE
- Senior Outcomes Checklist (SOC-10)

Conclusion

County mental health departments have consistently expressed two major concerns regarding the California Performance Outcome System (CPOS). The first pertains to a general confusion regarding the purpose and reliability of reports generated from the collection of the performance instruments. Counties have also expressed concerns about not receiving compiled reports related to the collected performance data.

DMH appears to recognize these concerns and cites several reasons why interpretations of data resulting from the CPOS should be viewed with caution. DMH notes that counties may not strictly comply with the data collection and reporting protocols. This can have negative effects on the comparability of data between counties. Comparability is also an issue when counties report on clients who are not within the target population. Also, mental health clients may refuse to complete one or more of the CPOS. This could result in a direct affect on the data analysis. Finally, each county is unique. Making strict comparisons between such diverse counties can be difficult.[54]

The second issue expressed by county mental health departments is the constant change that occurs to the CPOS. Counties note that certain required performance instruments may be changed or removed altogether. This causes frustrations and confusion for county staff members. They sometimes fail to see the purpose of completing certain performance instruments when they assume that DMH will change the procedure at some point in the future. Consequences of this confusion sometimes result in county non-compliance with performance data collection procedures.

DMH notes that the CPOS is an evolutionary process. A statewide survey was conducted on the CPOS, resulting in an understanding that change was needed in the system. Particularly, counties addressed concerns primarily with the CYPOS. Since that time, DMH has implemented a pilot program for a second phase. The new pilot program will address concerns brought up by counties, such as reliability of data and cost effectiveness.

DMH appears to continually review and attempt improvements to the CPOS. This is evident in the development of a second phase. The creation of the OAPOS pilot program also evidenced a need for change, showing that the current APOS did not adequately identify problems faced by older adults. While these attempts to improve the CPOS may cause confusion at the local levels, it appears to be a necessary factor in ultimately creating a standardized system required by the realignment legislation. In the end, good communication between DMH and the counties regarding the purpose of changes within the CPOS could be a critical factor in a smooth transition toward statewide CPOS standardization.

[54] Ibid.

CHART REVIEWS

We conducted chart reviews at each visited county mental health plan (MHP) to determine statewide documentation practices for services provided. Patterned questions provided an understanding of each county's chart practices. Using a chart review mechanism, we documented certain non-clinical attributes of beneficiary charts. We also performed a limited fiscal review to determine whether approved claims are supported, and toured several provider facilities to gain insight into the practical aspects of service delivery.

The nature and extent of our provider site visits is discussed in the Scope and Methodology section of this report, and our chart review mechanism, testing results, and a discussion of each tested attribute is documented in Appendix 1. This section presents our understanding of statewide charting requirements, our fieldwork observations, and results of our fiscal review.

Statewide Requirements

Neither the Welfare and Institutions Code (WIC) nor California Code of Regulations, Title 9, Chapter 11 (Title 9), specifically addresses charting requirements. Although chart documentation requirements are set forth in contracts between the Department of Mental Health (DMH) and MHPs, counties are given much interpretive leeway. Specifically, although the contract requires that beneficiary records address assessments, client plans, and progress note elements, "there is no requirement that the record have a specific document or section addressing these topics."[55]

The ambiguity of requirements almost guarantees statewide chart preparation and maintenance disparities. County staff communicated their lack of specific direction and commented that DMH quality assurance reviewers have, on occasion, found their county's interpretation of contract requirements to be out of compliance. County representatives were puzzled by this and expressed an interest in receiving guidance to help ensure their compliance.

Fieldwork Observations

Observations presented here are based on discussions with DMH representatives and site visits to ten MHPs, and may not represent processes and procedures in place at every MHP throughout California.

We did not undertake a clinical review of charts; rather we reviewed charts for certain attributes for which a clinical background is not necessary. We identified the following similarities and differences.[56]

[55] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C.

[56] Many of these issues are discussed in more detail in the Evaluation of Quality Chapter of this Report. To limit duplication, they are mentioned only briefly again here.

1. Providers maintain one chart per beneficiary, usually organized by episode. MHPs impose different chart requirements on different types of providers. Specifically:
    a. MHPs require county-operated providers to use standard forms and to conform to uniform chart documentation and organization practices.
    b. MHPs require contracted providers to use certain standard forms (such as assessments and client plans) but do not control the means by which contracted providers maintain and organize beneficiary charts.
    c. MHPs typically grant network fee-for-service providers discretionary control over both chart organization and content, and do not require use of standard forms.
    d. County-operated and contracted provider charts were generally well-organized records of treatment provided.
    e. Network fee-for-service provider charts, when provided, were seldom complete.
2. MHPs do not usually require centralized review of treatment results from all concurrent providers. Additionally, charts are infrequently shared among providers.[57] MHPs do, however, encourage communication and many charts document contact between providers regarding treatment of mutual beneficiaries. This may help ameliorate the almost universal lack of centralized review of treatment results.
3. County databases infrequently include information about all providers. Specifically, most Management Information System (MIS) databases used to identify providers treating MHP beneficiaries, do not include network fee-for-service providers.
4. Not all beneficiaries are assigned a case manager. Specifically, beneficiaries are approved for case management services based on impairment, need, and availability of provider staff, with higher-end users typically more targeted for services.
5. Quality of life assessments (QOL) are not documented in all beneficiary charts.
6. MHPs have inconsistent requirements for medication monitoring. Specifically:
    a. Most counties require attending psychiatrists to monitor medications at least periodically when prescriptions are refilled.
    b. Counties infrequently provide for quality reviews by a person other than the prescribing physician (such as a registered or licensed vocational nurse).
    c. Many MHPs provide for at least an annual review by a pharmacist, usually of between 5 percent and 10 percent of open charts.
    d. Primary and secondary reviews are documented in beneficiary charts. Reviews by pharmacists are not.
    e. Counties inconsistently employ technology in tracking of medications. Although most MHPs monitor prescriptions manually in beneficiary charts, one large, urban county relies completely on an online tracking system used by county-operated and contracted facilities (network fee-for-service providers are not included). The system checks prescriptions for duplication, appropriateness, and unusual trends or fluctuations. Exceptions are reviewed by the pharmacist and the medical director.
7. Counties inconsistently document consideration to cultural competency issues in charts. Specifically, some MHPs document attention to cultural diversity on assessments or client plans while others do not. Neither of these forms was observed in a language other than English.

[57] One small, rural county with a provider network of less than ten facilities located within ten miles of each other uses a single chart to document treatment delivered by all providers (except the inpatient hospital).

8. The scope and extent of quality management chart review protocols and procedures varies by county. Specifically:
    a. MHP representatives typically perform annual chart reviews of between 5 percent and 10 percent of beneficiaries active in the county system. One visited county performs no regular chart reviews.[58]
    b. Chart reviews are usually limited to county-operated and contracted providers; rarely are they performed at network fee-for-service providers.
    c. MHPs inconsistently review submitted claims for supporting documentation.
    d. Counties inconsistently require providers to perform their own internal quality management chart reviews.
9. Assessment preparation methodology and periodicity requirements differ greatly by MHP. Specifically comprehensive assessments are usually performed within four months of intake by, or under the supervision of, a Licensed Practitioner of the Healing Arts (LPHA). In some counties, beneficiaries are only formally assessed once, usually during the early phases of treatment, and updates are documented in progress notes at each beneficiary contact. In other counties, assessments are updated at various intervals ranging from biannually (twice a year) to triennially (every three years).
10. Charts consistently document beneficiary diagnoses from the Diagnostic and Statistical Manual, Fourth Edition (DSM IV) but infrequently document how beneficiaries meet the impairment and intervention criteria required by Title 9 for reimbursement of specialty mental health services. Specifically, although some counties use checklists to document medical necessity, most counties do not require express chart documentation of how beneficiaries meet medical necessity. In most cases, although a "prudent layperson" could review the chart and infer that the diagnosed condition causes an impairment of life functioning and that the intervention is planned to address the diagnosed condition, charts could be more complete if they document which of the impairment and intervention criteria apply to each beneficiary.
11. Client plan preparation methodology and periodicity requirements vary significantly by county. Specifically, plans are usually performed within four months of intake by, or under the supervision of, an LPHA. Additionally, although plans must be updated at least annually, they are often updated as often as every three to six months. Client plan goals are usually detailed and specific and relate to the diagnosed impairment.
12. MHPs consistently require progress notes to be detailed documentations of beneficiary visits, contacts with other parties or providers, and internal reviews for status in preparation for a beneficiary visit. Specifically, notes document case management services and discussions during therapy, group sessions, and medication visits.

Although we identified several other differences related to charting procedures (i.e., content and organization), they are not significant enough to warrant individual mention. Inherent diversity among MHPs, coupled with county flexibility to design responsive programs, helps explain these differences.

[58] This large, urban MHP performs exception reviews of county-operated and contracted provider charts, but does not review network fee-for-service provider charts. This county does require county-operated and contracted providers to self-assess charts. MHP staff may periodically verify information provided in self-assessments.

Fiscal Review

As discussed in the Scope and Methodology section of this report, DMH provided an itemization of approved SD/MC claims for services rendered from January 1, 2001 to June 30, 2001, for all beneficiaries selected for chart review. In conjunction with our review of beneficiary charts, we performed a limited fiscal review to determine whether these claimed billings were supported by source documentation. The scope of this review was limited to the items discussed in the Scope and Methodology section.

We determined that supporting documentation is generally available to support claimed amounts. We did identify a few exceptions, although they were too few in number to raise concern that claims are not supported. Specifically, we identified instances where billed time did not agree to time recorded on supporting documentation. Additionally, there were a few cases where we were unable to locate any documentation to support claimed amounts. County representatives cited misfiled documents as a possible explanation. Total identified exceptions were not material to total claims reviewed, and we concluded that progress notes and other documentary evidence are generally available to support approved claims.

Conclusion

Procedural disparities across California appear to be due to the ambiguity of charting requirements. The same flexibility that allows MHPs to design programs responsive to their beneficiaries' needs also invites inconsistencies. However, despite identified statewide inconsistencies, beneficiary charts at each facility generally appear to be a complete record of treatment provided. Though we acknowledge that counties appear to be individually working towards charting consistency, at least among county-operated and contracted providers, we encourage continued monitoring and review by MHPs and DMH, to work towards more uniform statewide application of charting procedures.

ADVOCATE GROUP PERSPECTIVES

Stakeholder participation is a major component of the consolidation movement in public managed care. Federal and state guidelines have encouraged advocate representation from the beginning, establishing a significant function to influence programs and policies. State planning councils, mental health plans' (MHPs) quality and monitoring committees, and patients' rights groups put advocates in the middle of all key decisions.

As one might expect, the goals of an advocate group are not always consistent with present state and federal guidelines. The advocate's role is to look outside the realm of compromise, offering clearly defined goals. The following beneficiary and provider advocate groups contributed their perspectives on the SMHSC waiver program:

- California Association of Social Rehabilitation Agencies (CASRA)
- California Council on Community Mental Health Agencies (CCMHA)
- California Mental Health Planning Council
- California Psychiatric Association
- Consumer Self-Help/Office of Patients' Rights
- Department of Mental Health, Office of the Ombudsman
- Mental Health Association, Sacramento Chapter
- Protection and Advocacy, Inc. (PAI)

The opinions expressed in this Chapter are not necessarily those of the independent assessors.

During our interviews, advocates made comments on the following topics in relation to the accessibility of public mental health services:

- **Gatekeeping:** Given present funding shortages, there is support for some kind of screening process, so that the most needful segments of society are assured services. While advocates understand the economic motivation to allocate limited service resources, most call for greater funding to promote complete coverage for all mentally ill persons.
- **Target populations:** While acknowledging the need for some form of gatekeeping, advocates continue to question the narrow beneficiary focus of "target population" criteria for medical necessity. They note the difficulties many mentally disabled individuals have when communicating their needs to intake staff. Potential beneficiaries fall through the cracks, not because they are ineligible for services, but because they are unable to navigate through systemic complexities. Many advocates push for non-Medi-Cal beneficiaries to receive some services. Presently, MHPs have no statutory obligation to provide for these individuals.
- **System bifurcation:** The continuing bifurcation of service delivery, resting on fee-for-service Medi-Cal (FFS/MC) and Short-Doyle Medi-Cal (SD/MC) models, is confusing for beneficiaries and providers. The limitations of FFS/MC (fewer providers and low fee

rates) and the narrow scope of SD/MC (target populations, funding limits, waiting lists, bureaucratic delays, and billing inconsistencies) further obscure access to services.

- **Emergency Room Utilization:** Emergency services are often used as a point of entry to county services, creating overuse and overcrowding of emergency rooms. Individuals who may have been initially "screened out" from MHP services go to emergency rooms to enter the system. Because MHP services and treatment are usually limited, future episodes force individuals back into the emergency room, resulting in a revolving door of care.
- **Waiting Lists:** Limitations brought on by the SMHSC waiver program have negatively impacted FFS/MC provider networks. Pay rates are well under industry averages for comparable services, giving private practitioners little incentive to join MHP networks, except in the larger counties where competition is higher. As a result, MHP waiting lists exist because only a limited number of providers can accommodate the ever-growing mental health population.

In regards to the quality of services provided to Medi-Cal beneficiaries, advocates also addressed the following topics:

- **Geographical Limitations:** County services are limited by area provider expertise. Smaller, rural counties tend to experience problems providing for adequate services through their MHPs. These counties can only provide services sustainable by county resources. Consequently, available services may not be sufficient for treatment requirements. Beneficiaries overcome these service shortfalls in their county of residence by "shopping" other counties for needed services.
- **Benchmarking:** The Department of Health Services or the Department of Mental Health (DMH) is in the best position to lead counties in an effort to establish "best practices." Benchmarking will effectively increase MHP uniformity and accountability. Consistent performance outcome measurements will ensure county compliance to federally mandated standards and help track MHP practices. This will assist California and counties to effectively project future programs and policies.
- **Pilot Programs:** Counties are awarded grants to counties to test program effectiveness, treatment methods, and service delivery systems. Pilot programs are seldom, if ever, adopted on a statewide basis. Advocates believe that pilot programs "get stuck" in the legislative budgeting process. When a program is initially implemented, funds are allocated to support the program until it is absorbed into the general budget. While the program may produce favorable and positive results, further funding is rarely available.
- **Bureaucratic Inertia:** Counties tend to oppose programmatic requirements imposed by DMH due to attached financial obligations. Resistance is prevalent in smaller and rural counties that experience funding inequities, and are therefore reluctant to take on the economic burden of new programs.
- **State Monitoring:** Counties are reviewed annually by DMH to ensure federal compliance. However, advocates contend that monitoring is too infrequent to address on-going deficiencies that impact the quality of care. To prevent inefficiencies, advocates want DMH to provide more frequent reviews.
- **Caseworker Overload:** Limited resources place burdens on staff to perform under stressful conditions. Caseworkers are experiencing "burnout" due to case overload and insufficient time to cover individual case needs; therefore, quality and timeliness are impacted.

Quality concerns center on the longstanding debate regarding therapy orientations. The Clinical Option uses medications as a stabilizing agent prior to more in-depth analysis. The

Rehabilitation Option (Rehab Option) builds treatment on a wide array of socialization skills training. Below are some opposing viewpoints about each discipline:

Rehab Option	Clinical Option
Treatment should be tailored to meet the unique needs of the individual.	Medi-Cal should return to this option because medicine is the core instrument for disease management and is used in all major health disciplines.
This option allows for beneficiary input regarding their treatment and care.	Psychiatrists want to move past the beneficiary's symptoms by first alleviating them with medications, followed by counseling.
Rehab Option moves away from institution-based service delivery systems. The Clinical Option remains embedded in a clinical setting.	Psychiatrists have been marginalized as the primary assessment and treatment clinician. They are generally used to prescribe drugs rather than contribute to the overall treatment plan.
Community-based outpatient treatments in non-clinical settings work best for promoting social interaction and independence.	Services provided by a psychiatrist are being handled by paraprofessionals, who lack the necessary medical training.
Clinical Option does not address the whole person.	Rehab Option gives beneficiaries a false sense of empowerment that does not work favorably in regards to effective treatment.

Regardless of any particular opinion, advocates agree that the SMHSC waiver program has been a positive step towards improved service delivery. The following briefly covers some positive elements of managed care:

- Managed care provides a wide variety of mental health services. Clustering all health care coverage, with a mental health carve-out, offers Medi-Cal beneficiaries greater access to mental health services than under pre-waiver conditions. Due to the integrated nature of managed care, the SMHSC waiver program enhances coordination.
- Counties find ways to deal with complaints on a local level before formal procedures are required by DMH.
- Services are monitored more thoroughly by oversight mechanisms imposed by state and federal mandates. Fee-for-service providers are held to a stricter standard than before the SMHSC waiver program.
- Services are limited in duration and must evidence some clear goal attainment plan. "Evidence-based practices" is an approach that requires proof of success, backed by quantifiable studies.
- Services consolidated from FFS/MC and SD/MC to managed care expanded benefits to all Medi-Cal beneficiaries.

During the course of our interviews, very few of the representatives addressed fiscal issues. One topic that advocates frequently mentioned was the addition of the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. EPSDT is a mandatory Medicaid service that requires states to provide a broad range of screening, diagnostic, and medically necessary treatment services for Medi-Cal beneficiaries under age 21. Many advocates consider this new addition to resources an advantage. Unfortunately, EPSDT programs become blended into the county's existing programs. Since the State does not monitor these funds, it is difficult to determine the effectiveness of the EPSDT program.

Conclusion:

Based on the discussions with advocate groups, we have concluded that overall access to services and the quality of services has improved due to the implementation of the SMHSC waiver program. Many believe that the public need would best be served by its continuation. Most of their concerns have been discussed in our report and may be addressed by the implementation of our recommendations. Those recommendations are stated at the conclusion of each Chapter of this report.

COST-EFFECTIVENESS ANALYSIS

As a condition of the Medi-Cal Specialty Mental Health Service Consolidation Waiver's (SMHSC waiver program) renewal, the State must demonstrate that its implementation is cost-effective/neutral. To complete this objective, we performed three types of analyses:

- Analysis of the SMHSC waiver program's cost effectiveness
- Analysis of the Upper Payment Limit
- Other analyses to determine the SMHSC waiver program's cost effectiveness

Analysis of the SMHSC Waiver Program's Cost Effectiveness

A component of this assessment's work plan is to determine whether the SMHSC waiver program is cost effective/neutral. This was performed by determining whether actual costs under the SMHSC waiver program were less than the Upper Payment Limit (UPL), the estimated annual costs without the SMHSC waiver program. Our cost effectiveness analysis used the three most current years of data available, namely fiscal years 1998-99, 1999-00, and 2000-01. As of the end of our fieldwork, the county Mental Health Plans (MHPs) had not yet submitted the 2001-02 cost reports. Therefore, we were unable to include these costs in our analysis.

To determine the cost effectiveness under the SMHSC waiver program, we initially compared the UPL calculated in California's Freedom of Choice Waiver Renewal Application[59] (waiver renewal) to the MHPs' actual claimed costs. The actual claimed costs were reimbursed under the federal financial participation (FFP) program. The FFP provides matching funds for the cost of services provided to Medi-Cal beneficiaries, with an annually adjusted reimbursement rate.

The cost effectiveness analysis included in the waiver renewal estimated beneficiaries to calculate a UPL. For our initial analysis, staff recomputed the waiver renewal's UPL using actual beneficiaries. Using actual beneficiaries increases the accuracy of the UPL comparison by eliminating the uncertainty of one variable.

We then compared the UPL adjusted for actual beneficiaries to actual costs. For 2000-01 UPL administration costs, staff calculated administration costs based on 12 percent of SD/MC costs because data was not available at the time. This initial comparative analysis of actual costs to the estimated UPL shows a cumulative savings under the SMHSC waiver program of $101,112,321. Table 22 summarizes this comparison.

[59] Waiver renewal application was submitted on June 1999.

Table 22—Comparison of UPL and Actual Costs

Waiver Costs	1998-99	1999-00	2000-01	Totals
UPL - Direct Services	$ 901,560,460	$ 962,556,845	$ 1,045,786,116	$ 2,909,903,421
UPL - Additional EPSDT[60]	114,812,839	115,723,531	115,546,740	346,083,110
UPL - Administration	64,656,549	71,436,151	79,892,122	215,984,822
TOTAL UPL	1,081,029,848	1,149,716,527	1,241,224,978	3,471,971,353
Actual Direct Services	872,969,456	1,002,741,352	1,164,311,176	3,040,021,984
Actual Administration	91,512,206	113,632,910	125,691,932	330,837,048
TOTAL ACTUAL	964,481,662	1,116,374,262	1,290,003,108	3,370,859,032
WAIVER SAVINGS	**$ 116,548,186**	**$ 33,342,265**	**$ (48,778,130)**	**$ 101,112,321**

Included in the waiver renewal was an analysis of the projected cost effectiveness during the waiver renewal period. The waiver renewal, which included revised estimates in a submittal to CMS, projected that total program savings under the SMHSC waiver program would amount to $218,396,323 for the period September 5, 1999 through September 4, 2001. Table 23 summarizes this revised estimate.

Table 23—Projected Total Program Savings during waiver renewal period

Periods	Total Costs Without the Waiver	Total Costs With the Waiver	Revised Total Program Savings[61]
9/5/99 - 9/4/00	1,120,161,921	1,011,772,565	108,389,356
9/5/00 – 9/4/01	1,171,094,040	1,061,087,073	110,006,967
Totals	**$2,291,255,961**	**$2,072,859,638**	**$218,396,323**

Although the time frames differ somewhat, a comparison of Table 22 with Table 23 discloses that the waiver renewal included estimates of program savings that are significantly higher than that actually realized. Although the waiver period exhibited overall cost savings for the three years we analyzed, the trend in savings was significantly decreasing, and reversed itself in 2000-01. The downward trend we observed during the fiscal years reviewed suggests that costs savings under the SMHSC waiver program are non-existent after 2000-01. One significant reason for this trend could be due to the Early Periodic Screening Diagnoses and Treatment (EPSDT) program.

EPSDT began in 1967 as a mandatory Medicaid service requiring states to provide a broad range of screening, diagnostic, and medically necessary treatment services for Medi-Cal beneficiaries under age 21. Two types of costs are associated with EPSDT. One of those costs, baseline EPSDT, is identified as existing program costs that meet the criteria established for EPSDT programs. These costs are incurred as Short-Doyle Medi-Cal (SD/MC)

[60] Data represents actual costs as reflected in the revised submittal to CMS.
[61] Revised total program savings represent a revision in the waiver application that was completed on the waiver renewal.

Rehabilitation costs, and would have been incurred with or without the SMHSC waiver program. Increases in these qualifying programs and their costs above baseline funding represent the second cost, additional EPSDT. In 1995-96, the Department of Mental Health (DMH) and the Department of Health Services (DHS) reached an agreement (EPSDT agreement) to provide state matching funds for increases in the growth of additional EPSDT costs. The EPSDT agreement allowed county MHPs to expand EPSDT programs without increasing the MHPs' costs to provide these services. Since this agreement was implemented, EPSDT costs have increased dramatically.

Because the California Freedom of Choice Inpatient Consolidation Waiver[62] (initial waiver) was instituted prior to the EPSDT agreement, the UPL calculation accounted only for baseline EPSDT programs, which would have been incurred with or without the SMHSC waiver program. The last year of actual data for calculating the UPL for the initial waiver was 1993-94; therefore, continual increases in additional EPSDT funding did not appear in historical trend data used for computing the UPL. Additional EPSDT program growth, exacerbated by the EPSDT agreement, was not included. However, the waiver renewal did include additional EPSDT costs in the UPL calculation as shown in Table 22. The waiver renewal methodology assumes that all additional EPSDT costs would be due to the implementation of new EPSDT programs and the growth of existing EPSDT programs because of the EPSDT agreement.

Our initial analysis disclosed that in recent years, EPSDT costs have been rising significantly. Total costs for EPSDT in 2000-01 represented 40.1 percent ($519,639,383/$1,295,993,898) of the state's total mental health budget for the SMHSC waiver program. Table 24 illustrates that for the three years of data analyzed in this assessment, increases in EPSDT costs represent 70.23 percent of the increase in the state's total waiver costs. As indicated, increases in EPSDT costs represent the majority of waiver cost increases.

Table 24—Changes in EPSDT Costs as Compared to Changes in Total Waiver Costs

	1997-98 to 1998-99	1998-99 to 1999-00	1999-00 to 2000-01	Totals
Change in Total Waiver Costs	$71,828,676	$151,892,599	$179,619,637	$ 403,340,912
Change in EPSDT costs	63,413,560	95,748,240	124,098,796	283,260,596
Percentage Changes in Total Waiver Costs Represented by EPSDT	88.28%	63.04%	69.09%	70.23%

The significant increases in EPSDT give rise to another concern regarding the program's cost control mechanism. The MHPs control the administration of EPSDT programs while the State provides funding for all additional costs above the baseline, which is non-federally funded. In the analysis of the 1999-00 budget,[63] the Legislative Analyst Office (LAO) states that this "split between funding and program responsibility creates a lack of cost-control incentives." The report goes on to say that MHPs "have a fiscal incentive to shift costs to the EPSDT program whenever possible." One reason for the incentive is the lack of controls the State has placed on MHPs for EPSDT expenditures.

Because MHPs could shift costs from existing waiver programs to their EPSDT programs, any cost effectiveness analysis may be obscured. As previously discussed, the waiver renewal's

[62] California's Freedom of Choice Inpatient Consolidation Waiver was the initial waiver program that California instituted on March 17, 1995.
[63] LAO Analysis of the 1999-00 Budget Bill.

cost effectiveness section makes the assumption that additional EPSDT costs that rise above baseline would represent costs for new EPSDT programs, or growth in existing EPSDT programs that would be the same with or without the SMHSC waiver program. However, if the MHPs were shifting costs from existing waiver programs to EPSDT programs, then those existing program costs have already been accounted for in the UPL. If existing costs are shifted to additional EPSDT costs, then the assumption concerning additional EPSDT costs, made in the waiver renewal, is not valid. However, there is no method to determine the exact impact additional EPSDT would have on the UPL because of the lack of oversight of EPSDT expenditures by the State.

The LAO report[64] on the 2001-02 DMH budget states that one main reason for the overall cost increase is due to the expansion of EPSDT for children with emotional problems. The report also states that EPSDT is growing annually by 28 percent. During our review, we determined that the actual EPSDT growth rate for 1998-99 through 2000-01 is approximately 30.05 percent. However, the UPL calculation in the waiver renewal only predicted a 2 percent annual growth rate of additional EPSDT costs for this period, significantly understating the waiver renewal's calculation of the UPL.

The waiver renewal estimated additional EPSDT costs as $115,546,740 for 2000-01. This amount is less than the actual additional EPSDT costs[65] for that year of $412,059,458. The difference of $296,512,718 appears to obscure the waiver's true cost.

In order to adjust for the underestimates of additional EPSDT growth and to provide a more accurate calculation of cost effectiveness, we performed another computation by using actual, not estimated, additional EPSDT, in the UPL. This revised comparison shows a savings under the SMHSC waiver program for all years reviewed. Table 25 summarizes the revised cost effectiveness comparison.

Table 25—Revised Comparison of UPL to Actual Expenditures

Waiver Costs	1998-99	1999-00	2000-01	Totals
Total UPL with estimated additional EPSDT	$1,081,029,848	$1,149,716,527	$1,241,224,978	$ 3,471,971,353
Difference between estimated and actual additional EPSDT	77,399,583	172,237,131	296,512,718	546,149,432
Recalculated UPL with actual additional EPSDT	1,158,429,431	1,321,953,658	1,537,737,696	4,018,120,785
Actual Costs Under Waiver	964,481,662	1,116,374,262	1,290,003,108	3,370,859,032
Recalculated WAIVER SAVINGS with actual additional EPSDT	**$ 193,947,769**	**$ 205,579,396**	**$ 247,734,588**	**$ 647,261,753**

[64] LAO Analysis of the 2001-02 Budget Bill.
[65] DMH, Systems Implementation: Special Projects Section. Section provided Actual EPSDT costs and cost estimates.
[66] LAO Analysis of the 1999-00 Budget Bill.

Analysis of the Upper Payment Limit

The UPL represents the cost for services had the SMHSC waiver program not been in place. The UPL helps measure the cost effectiveness of a plan operating under a waiver by providing a comparative point of reference. A component of this assessment's work plan is the analysis of the UPL calculation, including a validation of the UPL's assumptions and methodology. Furthermore, the work plan includes the comparison of inflation rates used in computing the UPL to actual inflation rates for Per Member Per Month (PMPM) calculations.

The initial waiver estimated the UPL by using actual 1993-94 data identified by aid code, adjusted annually by a utilization factor, pricing factor, and other factors. The utilization factor represented the percentage change in Medi-Cal eligibles for each aid code group. The pricing factor equaled the National Consumer Price Index (CPI) medical component. Other factors included unspecified changes related to quality and productivity of services unique to each Medi-Cal aid group.

The waiver renewal states that the methodology used to calculate its UPL was a continuation of the methodology used for the California Freedom of Choice Consolidation Waiver[67] (subsequent waiver). However, the waiver renewal calculations for cost effectiveness used only historical trends and other unspecified changes. Based on the data included in the waiver renewal, utilization and pricing factors were not included in the computations. In our analysis of the UPL calculations, we had concerns with the following issues: use of historical trends, computation of PMPM rates for individual service areas, and penetration rates.

UPL Based on Historical Trends

As previously stated, the UPL in the waiver renewal application is based on historical trends. These trends are based on 1993-94 data, the last year for which actual data was available. Since September 9, 1994, a waiver has been in place, eliminating the availability of actual, non-waiver costs.

This poses an additional problem with the UPL and the actual cost information used in its calculation. The actual data is nearly nine years old and is less likely to account for unforeseen changes in the environment or economy. For example, the actual information used in the waiver renewal UPL could not anticipate the changes in costs that were caused by the EPSDT agreement.

Computation of the PMPM Rates

PMPM rates were computed for individual service areas. The UPL methodology in the waiver renewal calculates the PMPM rates for the following individual service areas: Fee for Service Medi-Cal (FFS/MC) Inpatient, FFS/MC Outpatient, SD/MC Inpatient, and SD/MC Rehabilitation/ Case Management. The waiver renewal included a comparison of the UPL to actual costs during the subsequent waiver period and to estimated actual costs during the waiver renewal period. However, we noted that an evaluation of the UPL by comparing those costs creates problems.

The initial and subsequent waivers consolidated inpatient and outpatient services from FFS/MC to SD/MC. While the category of FFS/MC Inpatient Services was not completely eliminated, the category of FFS/MC Outpatient Services was. Due to the consolidation of service categories

[67] California's Freedom of Choice Consolidation Waiver was a continuation of the initial waiver program that was modified and renamed to include outpatient services instituted on September 5, 1997.

implemented under the two waivers, comparison to estimated UPL rates, which is calculated on individual service areas, is difficult, if not impossible, to ascertain. For example, recorded actual costs for FFS/MC Professional Services are non-existent after 1997-98, due to the consolidation of this category into SD/MC. However, without the SMHSC waiver program, the individual area of FFS/MC Professional Services would still exist, and would be included in the computation of the UPL, identified by its own individual service area. Therefore, the waiver renewal UPL's PMPM rate of each type of service for a particular aid group (which costs are not consolidated) cannot be compared to actual costs after the consolidation of the subsequent waiver.

To enable an assessment of the accuracy of the UPL, we combined the FFS/MC and SD/MC costs into total costs per aid group and calculated a PMPM rate for those costs. Separating the costs into these aid groups allows a more accurate comparison of costs. However, using the UPL's PMPM rate as a means of comparison to actual costs creates another problem specific to this SMHSC waiver program.

One disadvantage in comparing the PMPM rates is the fluctuations in costs caused by the implementation of the two waivers. These fluctuations represent program changes as well as elimination of programs, like the FFS/MC Outpatient Services, that are not the result of natural changes in environment or inflation. Therefore, we compared PMPM cost rates for those years subsequent to the implementation of the waiver renewal, to provide a more equalized basis to assess the appropriateness of a UPL.

We calculated the actual PMPM rates and changes for each of the three aid groups as summarized in Table 26. We also recalculated the PMPM rates estimated in the UPL for the three aid groups to eliminate the individual areas of FFS/MC and SD/MC. A comparison of PMPM actual rate to the PMPM estimated rate (Table 26) was performed to provide a measure of the reasonableness of the UPL used in the waiver renewal.

Table 26—Comparison of Actual Costs PMPM to Estimated Costs PMPM Under the Waiver

Aid Group Categories			1998-99	1999-00	2000-01
Disabled	PMPM	(Actual)	$55.48	$59.16	$63.18
	% Change		6.47%	6.65%	6.79%
	PMPM	(Estimated)	$55.41	$56.81	$58.45
	% Change		2.08%	2.53%	2.89%
AFDC[68]	PMPM	(Actual)	$8.23	$10.41	$12.37
	% Change		18.03%	26.51%	18.80%
	PMPM	(Estimated)	$8.15	$9.25	$10.51
	% Change		15.84%	13.50%	13.62%
Other	PMPM	(Actual)	$1.74	$1.76	$1.81
	% Change		-45.78%	0.81%	2.89%
	PMPM	(Estimated)	$4.40	$4.42	$4.45
	% Change		-0.04%	0.45%	0.68%
Total	PMPM	(Actual)	$14.00	$15.91	$17.42
	% Change		8.05%	13.68%	9.47%
	PMPM	(Estimated)	$14.68	$15.94	$17.31
	% Change		7.30%	8.56%	8.57%

The analysis discloses that the waiver renewal underestimated the UPL's PMPM rate and its related changes for all aid groups. The following examples demonstrate this conclusion. For the Other aid group for 1998-99, the percentage change in estimated costs PMPM was -0.04 percent while the actual percentage change decreased by -45.78 percent. This analysis showed that Medi-Cal beneficiaries, a component of the PMPM rate calculation, had an inverse relationship to actual costs when a direct relationship should exist. For 1998-99, the actual costs for the Other aid group decreased by 44.8 percent and number of Medi-Cal beneficiaries for the same group increased by 1.8 percent. Again, the inverse relationship between Medi-Cal beneficiaries and actual costs could explain the large variance between the estimated and actual PMPM rates. This variance between the rates and the related changes under the SMHSC waiver program could indicate deficiencies in the methodology used to compute the UPL in the waiver renewal. To further explain these deficiencies, an analysis of the penetration rates needs to be performed.

Penetration Rates

Penetration rates, as defined in the Access Chapter of our Report, represents the number of unduplicated beneficiaries that access MHP programs (unduplicated beneficiaries) divided by the number of total Medi-Cal beneficiaries. Table 27 summarizes the penetration rates, separated by beneficiary aid group for the last five years of available data.

[68] AFDC aid group include two aid groups, Families and Foster care Aid Groups, so that staff could compare actual costs to those estimated in the waiver renewal. The waiver renewal combined these groups in its analysis. AFDC is now known as Temporary Aid to Needy Families (TANF).

As stated previously, our analysis disclosed deficiencies in the PMPM rates that were used to compute the UPL. The penetration rate establishes a relationship between Medi-Cal beneficiaries and unduplicated beneficiaries. Significant changes in that relationship would skew the related PMPM rate. This is pointed out by the previous example which shows that the percentage change in actual costs PMPM from 1997-98 to 1998-99 decreased by –45.78 percent. While the data suggests that the PMPM rate for the Other aid group is decreasing dramatically, this conclusion is incorrect.

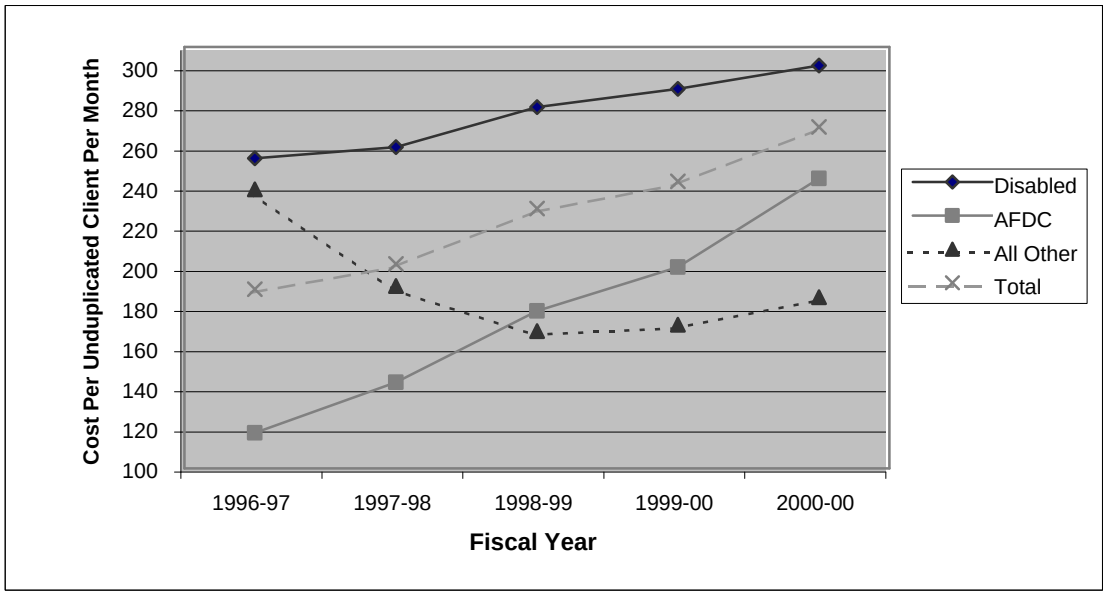
Table 27 shows that the penetration rate for the Other aid group decreased by 38.1 percent ([1.04% / 1.68%] - 1) from 1997-98 to 1998-99, which corresponds with the 37.4 percent ([13,335 / 21,310] – 1) change in unduplicated beneficiaries. The decreasing 37.4 percent change in unduplicated beneficiaries corresponds with the 44.8 percent decrease in actual costs for the Other aid group as opposed to the 1.8 percent increasing change in Medi-Cal beneficiaries. The possible inverse relationship does not justify the PMPM rate as a sound methodology for determining cost effectiveness because changes in funding should have a direct relationship to the changes in Medi-Cal beneficiaries. Therefore, the correlation between Medi-Cal beneficiaries and waiver costs may not be valid. The change in Medi-Cal beneficiaries for Other aid group does not accurately represent changes in the Other aid group costs.

Table 27—Penetration Rate Calculation

Unduplicated Beneficiaries					
Aid Groups	**1996-97**	**1997-98**	**1998-99**	**1999-00**	**2000-01**
Disabled	153,928	159,135	160,724	169,966	178,649
AFDC	151,786	153,274	142,881	160,010	166,570
All Other	16,543	21,310	13,335	13,757	13,940
Totals	322,257	333,719	316,940	343,733	359,159
Medi-Cal Beneficiaries					
Disabled	788,271	793,856	811,131	830,805	850,315
AFDC	3,388,654	3,140,405	3,098,811	3,077,864	3,291,829
All Other	1,308,311	1,265,110	1,287,795	1,343,339	1,428,539
Totals	5,485,236	5,199,371	5,197,737	5,252,008	5,570,683
% Of Unduplicated Beneficiaries accessing MHPs (Penetration Rate)					
Disabled	19.53%	20.05%	19.81%	20.46%	21.01%
AFDC	4.48%	4.88%	4.61%	5.20%	5.06%
All Other	1.26%	1.68%	1.04%	1.02%	0.98%
Totals	5.87%	6.42%	6.10%	6.54%	6.45%

The PMPM rate used to calculate costs may not be an accurate measure of the waiver renewal's cost effectiveness. A more accurate measure may be the use of unduplicated beneficiaries in place of Medi-Cal beneficiaries. The PMPM rate was developed to assess the cost effectiveness of capitated systems of managed health care. As of yet, the SMHSC waiver program is not a capitated managed health care system. The Per Unduplicated Client Per Month rate could accurately reflect costs and eliminate some of the large variances for the individual aid group averages as compared to the state average. Table 28 summarizes the change in per unduplicated beneficiary per month rate.

Table 28—Medi-Cal Actual Costs Per Unduplicated Client per Month



Other Analyses

The work plan recommends some approaches to the cost effectiveness analysis, which includes determining whether recipients and services are decreasing. Table 27 illustrates that the number of unduplicated beneficiaries accessing MHP programs has increased every year except 1998-99. It appears that services are also increasing, as discussed in the Access Chapter of this Report. Because of increases in the number of beneficiaries accessing MHP programs and the increases in the services they are receiving, there would not be cost savings associated with this indicator. Cost savings are difficult to compute because of the aforementioned increases in EPSDT programs that affect both the FFS/MC and SD/MC systems. However, our analysis explains one possible component of the SMHSC waiver program's cost savings: the consolidation of FFS/MC Professional Services, due to the implementation of the subsequent waiver.

An element in the review of the UPL, as listed in the work plan, requires an evaluation of the State's monitoring of cost effectiveness. We could find no evidence that the State monitors cost effectiveness other than during the preparation of the waiver renewal submitted for the SMHSC waiver program.

An additional component of the assessment work plan suggests analyzing the shifting of costs from the MHPs to easily substitutable FFS/MC costs. We identified the substitution of pharmaceuticals for other services as the only area where this substitution could take place. The MHPs bear no responsibility for the cost of medications. However, the analysis of shifting costs from the MHPs to pharmaceuticals cannot be performed because the State does not monitor pharmaceutical utilization rates. An analysis of this issue was discussed in the Quality Chapter of this Report.

An additional method for assessing cost effectiveness includes using a comparable population. Finding a comparable population is impossible because of the size and diversity of California's Medi-Cal population. For these reason, our cost effectiveness assessment did not include using the comparable population method.

Conclusion/Recommendations

In general, we determined that the implementation of the SMHSC waiver program appears cost-effective/neutral. Over the three-year period, we estimated total program savings of $647,261,753. However, we did not reach this conclusion with absolute certainty because of the indeterminate effect of the unexpected growth in additional EPSDT costs. We also determined that:

- The methodology used to calculate the CMS-approved UPL is based only on historical trends, and does not provide accurate estimates.
- EPSDT costs represent 40 percent of overall waiver costs and 70 percent of increases in waiver costs for all three years. Those costs are projected to continue to grow at a large rate.
- EPSDT costs are not tracked by MHPs because the State requires no oversight of EPSDT expenditures.

We make the following recommendations based on our cost effectiveness analysis:

- Revise the methodology used to calculate the UPL. The calculations should be performed by an actuary, or based on a sound methodology, similar to that contained in the DHS *Upper Payment Limit Rate Methodology Manual.*
- Use unduplicated beneficiaries instead of the number of Medi-Cal beneficiaries in UPL calculations. Currently, the SMHSC waiver program is not capitated and therefore, should not use the PMPM calculation in its UPL.
- Implement program controls requiring the MHPs to track EPSDT expenditures.
- Employ monitoring of the SMHSC waiver program's cost effectiveness.

CONCLUSION

Based on our independent assessment of the SMHSC waiver program, we concluded that the SMHSC waiver program resulted in improved access and quality of care, and the SMHSC waiver program was cost-effective/neutral. We met with DMH and DHS representatives on July 10, 2002, to discuss the issues presented in this report.

This report is intended for the information and use of the Federal Centers for Medicare and Medicaid Services, State Departments of Health Services and Mental Health, and participating County Mental Health Plans, and is not intended to be and should not be used by anyone other than the specified parties. However, this report is a matter of public record and its distribution is not limited.

REFERENCE

1. California Code of Regulations (CCR), Title 9, Division 1, Sections 1810.100-1850.505.
2. CCR Title 22, Division 3, Subdivision 1.
3. California Government Code.
4. California Health and Safety Code.
5. Code of Federal Regulations (CFR), Title 42.
6. Public Law 99-660, Title V (1986).
7. Public Law 102-321 (1992).
8. The Social Security Act, Title 19.
9. Website for California Department of Mental Health.
10. Welfare and Institutions Code (WIC), Sections 5600-5623.5; 5775-5780; 14680-14685.
11. Adult Performance Outcome System Clinical Training Manual, Version 2; California Department of Mental Health, August 1999.
12. Annual Review Protocol For Consolidated Specialty Mental Health Services and Other Funded Services Instructions to Reviewers for fiscal year 2001-02 prepared by the California Department of Mental Health.
13. California's Medi-Cal Specialty Mental Health Services Consolidation Section 1915(b) Request for Waiver Renewal ("Waiver Request") prepared by the California Department of Mental Health in June 1999.
14. California Department of Mental Health Cost & Financial Reporting System 2000-01 Cost Report Instruction Manual.
15. California Department of Mental Health Onsite Review Findings of the ten visited County Mental Health Plans. Reviews conducted in 2000 and 2001. Results summarized in Appendix 2.
16. California Mental Health Master Plan (Draft); California Department of Mental Health, 2001 revision date.
17. California Quality of Life Survey Reports and Mental Health Statistics Improvement Program Consumer Survey Reports for 2000 & 2001.
18. Children/Youth Performance Outcome System Clinical Training Manual, California Department of Mental Health, January 10, 2001 version.
19. County Mental Health Plan Implementation Plans (Performance Contracts) originally submitted August 1997 through March 1998 for the ten visited County Mental Health Plans.
20. Performance Measure Results on California's Community Mental Health Performance Outcome Systems: Annual Report to the Fiscal and Policy Committee of the Legislature in Response to Chapter 89, Statutes of 1991 Assembly Bill 1288, WIC 5613; California Department of Mental Health, March 2001.
21. Standard contract between California Department of Mental Health and County Mental Health Plans for fiscal year 2000-01.
22. "Being There: Making a Commitment to Mental Health" prepared by the Little Hoover Commission in November 2000.
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27. "Major Milestones: 43 Years of Care and Treatment of the Mentally Ill" prepared by the Legislative Analyst's Office on March 2, 2000.
28. “Managed Care for Public Mental Health Yields Mixed Results” by Michael Jonathan Grinfeld, Psychiatric Times, April 2000.
29. “Managing Mental Health Care: A Report on California’s Medi-Cal Mental Health System 1997-1999” prepared by Protection and Advocacy, Inc. in consultation with Beth C. Stoneking, Ph.D. University of Arizona, Health Services Center in January 2000.
30. "Mapping the Flow of Eligibility and Encounter Data in Medi-Cal Managed Care" prepared by Outlook Associates, Inc. in March 2001.
31. “Medicaid Waivers: California’s Use of a Federal Option” prepared by Valerie Lewis, M.P.P., M.P.H., Medi-Cal Policy Institute in March 2000.
32. “Performance Measurement Data,” California Department of Mental Health, January 2002.
33. “Psychiatric Hospital Beds in California: Reduced Numbers Create System Slow-Down and Potential Crisis,” California Institute for Mental Health, August 30, 2001.
34. “Reviews of Medi-Cal Managed Care Plans Show Disappointing Results” by Legislative Analyst’s Office, Update California, August 1998.
35. “Rising EPSDT Costs a Continuing Concern” by Legislative Analyst’s Office, 2001 Budget Analysis: Department of Mental Health, 1999.

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

DIANA M. BONTÁ, R.N., Dr. P.H.
Director

GRAY DAVIS
Governor

October 29, 2002

Mr. Samuel E. Hull, Chief
Office of State Audits and Evaluations
Department of Finance
915 L Street
Sacramento, CA 95814-3706

Dear Mr. Hull:

DEPARTMENT OF FINANCE DRAFT INDEPENDENT WAIVER ASSESSMENT OF THE MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES WAIVER (TERM: NOVEMBER 20, 2000 THROUGH NOVEMBER 19, 2002)

The Department of Health Services (DHS) has completed review of the above referenced Draft Independent Waiver Assessment (IWA) and the enclosed Department of Mental Health's (DMH) Responses to the Draft IWA.

DHS is pleased with the IWA's overall conclusion that the waiver improved access and quality of care, and was cost-effective/neutral. Based on DHS' review of the draft IWA and DMH responses, DHS and DMH will continue to work collaboratively to ensure that state and federal laws and regulations pertaining to Medicaid and federal Social Security Act Section 1915 (b) Medicaid waivers are met.

DHS appreciates your efforts in completing the IWA and will consider your findings and recommendations in both the current and future waiver renewals. If you have any questions, please contact Mr. Roberto B. Martinez, Chief of the Medi-Cal Policy Division, at (916) 657-1542.

Sincerely,

Gail Margolis

Gail L. Margolis, Esq.
Deputy Director
Medical Services

Enclosures

DEPARTMENT OF MENTAL HEALTH RESPONSES TO THE DRAFT INDEPENDENT ASSESSMENT OF THE MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES CONSOLIDATION WAIVER PREPARED BY THE DEPARTMENT OF FINANCE, MAY 2002

The Department of Mental Health (DMH) has reviewed the draft Independent Waiver Assessment (IWA) report on the Medi-Cal Specialty Mental Health Services Consolidation waiver program (SMHSC) prepared by the Department of Finance under, contract to the Department of Health Services (DHS). DMH submits the following responses and clarifications regarding the findings in the report. -The bullet points cite the concerns and/or recommendations identified in the Executive Summary of the IW A and include the page on which the issue is discussed in depth. Following each bullet point is a more detailed description of the concern and/or recommendation, if necessary, and the DMH response. Responses are organized in the same format as the IWA. Some areas of concern and recommendations appeared duplicative of others. In this case, a cross-reference to the earlier discussion is made.

Evaluation of Access

The IWA finds that the SMHSC has improved access overall, but goes on to identify the following areas in which the reviewers believe additional improvements could be made.

- ***Concern:*** **Provider ability to self-assess capacity and the lack of standards governing provider capacity (IWA, pages 16-17).** ***Recommendation:*** **DMH should require higher levels of capacity monitoring by network fee-for-service providers to reduce instances of service delay (IWA, Pg. 21).**

The findings in the IWA indicate a concern that the "lack of monitoring could result in providers over-estimating their capacity levels which could lead to excessive waiting periods for clients to receive services." DMH acknowledges the concern, but does not believe that requiring more rigorous monitoring of fee-for-service (FFS) provider, capacity would be an effective use of limited mental health plan (MHP) resources. MHPs are required through their contracts to set goals for timeliness of services as part of their annual Quality Improvement work plans. DMH will continue to monitor this area through the annual Medi-Cal Oversight review and the review of the annual work plan.

- ***Concern:*** **County supplementation of the State Maximum Allowance {SMA) to recruit and/or retain particular providers (IWA, Pg. 17).**

The IWA found that some individual providers receive FFS rates that exceed the SMA and expressed a concern that offering providers rates higher than the SMA potentially leads to uneven levels of access. DMH believes the finding is based on a misunderstanding of the reimbursement system applicable to MHPs and providers under the waiver. The SMA for a particular service represents the maximum average cost of that type of service, not the maximum reimbursement for any individual service Federal reimbursement to MHPs for the services the MHPs provide directly and the services delivered by contracting individual and group providers (usually former FFS Medi-Cal (FFS/MC) providers) may not exceed SMA on average. A payment to a provider for an individual service or type of service may exceed the SMA. Medication support services, for example

has an SMA of $4.09 per minute for fiscal year (FY) 2001-02 ($245.40 per 60-minute hour, $61.35 for a 15 minute visit). Medication support services includes services delivered by psychiatrists, pharmacists, registered nurses, licensed vocational nurses, and psychiatric technicians. It is expected that psychiatrists, especially child psychiatrists, would receive higher actual rates of payment than the other mental health professionals, since the psychiatrist's scope of practice is much broader and since psychiatrists are difficult to recruit. Although DMH does not think it's likely that all psychiatrists would receive more than $245.40 an hour, it would be appropriate to pay this rate if it was required to ensure access.

The IWA also mentions "patches" as an issue related to supplementation of the SMA. Generally, the term "patches" has been used to describe supplemental payments county mental health departments have made to residential facilities above any payments the facilities receive in per diem or for treatment services. These patches are sometimes paid to cover additional mental health services (beyond Medi-Cal services or services included in the per diem rate) and sometimes are payments required by the facility for admission. Group homes that specialize in foster children with serious mental health problems and board and care homes that serve populations who are mentally ill have been paid such patches. Patches are not additional payments for Medi-Cal services and .are not governed by the waiver.

- ***Concern:*** **The uneven historical funding base for counties and the relationship it has to current utilization and penetration rates (IWA, Pg. 17-18).**

The IWA mentions the uneven historical funding in the public mental health system and assumes that this will result in inequities in utilization and penetration rates. The IWA quotes a DMH planning document for SMHSC that cites historical inequities as an issue of concern. The IWA, however, does not comment on the features of realignment and of the SMHSC allocation process that addressed these issues.

Since 1991, realignment has been the State's primary system for funding county health, social service, and mental programs. Under realignment, sales and motor vehicle tax revenues are transferred to the counties following statutory formulas based on historical costs of the county programs. A portion of the annual growth in realignment revenues was set aside to provide enhanced funding to "under-equity" counties, until a reasonable equity level was reached. This level was reached in FY 2001-02.

The allocation of state general funds (SGFs) to the MHPs under SMHSC provided a similar mechanism to reduce the historical inequities. The annual allocation to MHPs is based on the historical cost of the new services for which the MHPs assumed responsibility under SMHSC (mainly former FFS/MC psychiatric inpatient hospital services, psychiatrist services and psychologists). Although the initial allocations were based on historical expenditures by the FFS/MC program in each county, subsequent allocations provided all growth due to cost of living adjustments and increases in the number of Medi-Cal beneficiaries to MHPs based on weighted relative need, which reflects the percentage of total need a MHP required to equal to the statewide weighted average cost per Medi-Cal beneficiary in FY 1993-94, weighted by Medi-Cal aid code group (note that relative need in FY 1995-96, the first year under the waiver program, was

calculated separately for each aid code group and was not weighted). Growth dollars have been allocated to 36 MHPs. The remaining MHPs have received increases in their overall allocations due to the inclusion of FFS/MC professional services under the waiver in 19971 FFS/MC provider rate increases and other minor program changes. MHPs continue to receive federal financial participation (FFP) and additional SGFs for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) based on the services actually delivered to beneficiaries.

Both the State and the Centers for Medicare and Medicaid Services (CMS) are limited in their options to address historical inequities under waiver programs by the need to ensure that the program is cost-effective.

- ***Concern:*** **The shortage of general and child psychiatric services, and resultant waiting lists and appointment delays (IWA, Pg. 18-19).**

While DMH acknowledges that there is a state and nationwide shortage of general and child psychiatric providers, especially child psychiatrists, DMH does not believe that this is a situation caused or exacerbated by the Medi-Cal Specialty Mental Health Services Consolidation waiver program. The human resource shortage crosses all mental health professional and paraprofessional groups and is experienced daily in crisis proportions by mental health consumers and practitioners across the country. It is true that this shortage has impacted and continues to impact California MHPs significantly and likely results in appointment delays and waiting times. DMH believes the related problems would exist with or without the waiver. As acknowledged in the IWA, the California Mental Health Planning Council has devoted the last two years to studying this problem and is in the process of developing a report that will make several recommendations to address the issue in California.

- ***Concern:*** **Hospital bed shortages and the lack of step-down facilities (IWA, Pg. 19-20).**

DMH concurs with the finding that there is a serious shortage of step-down facilities, which is also compounded by the shortage of hospital beds. DMH does not agree that it is an issue that can be resolved through the waiver program. The IW A appears to define step-down facilities as group homes for foster children and licensed board and care homes for adults. These types of step-down facilities are not covered by the Medi-Cal program and, therefore, the lack is not a direct responsibility of SMHSC. DMH and MHPs, because they are County mental health departments with responsibilities for the public mental health system as a whole, continue to work with other stakeholders to resolve some of these very difficult issues.

The number of FFS/MC psychiatric inpatient hospital services providers decreased slightly from FY 1996-97 (prior to the first SMHSC waiver renewal period) through FY 2001-02 due to a number of hospitals closing their psychiatric units: 121 FFS/MC psychiatric inpatient hospitals provided services in FY 1996-97, while 95 FFS/MC psychiatric inpatient hospitals provided services in FY 2001-02. The number of Short- Doyle/Medi-Cal (SD/MC) hospitals has also decreased from 29 in 1996-97 to 24 in FY 2001-02. The decline in participating hospitals is a result of reductions that are occurring for all populations in California and nationally, not a result of SMHSC alone. To some extent, the decline represents a positive trend toward early intervention and community-based, rather than institutional, treatment of individuals in crisis. On the other hand, ensuring the availability

of psychiatric inpatient hospital services, when necessary, is essential to continued successful operation of the waiver program. DMH is continuing to study this problem and work towards potential solutions. The State Quality Improvement Council (SQIC} is currently studying several issues related to psychiatric inpatient hospital services, including a re-hospitalization rate special study conducted by the SQIC Inpatient Treatment Review Workgroup. DMH also participates with the California Healthcare Association representing hospitals, the California Mental, Health Directors' Association, representing MHPs, and other stakeholders in a workgroup on the hospital bed shortage.

The findings also identify the Institutions for Mental Disease (IMD) exclusion under Medicaid law as a barrier for placing adult beneficiaries. DMH agrees that this is a problem; however, it is not a problem that the waiver program can resolve. Neither the State nor CMS has the authority to ignore the IMD exclusion in the waiver program. DMH agrees with the IWA recommendation that the IMD exclusion should be re- examined.

- ***Concern:*** **The uneven provision of Medi-Cal reimbursable services (IWA, Pg. 20).**

The IWA finds that SMHSC does not establish statewide criteria for how services must be delivered, thereby creating the possibility that different clinicians will approach treatment of similar impairments in different ways, depending on their specific field of practice. DMH concurs with the statement, but does not agree that this is a problem. To suggest that treatment for similar conditions should be treated the same way statewide assumes that all beneficiaries with a specific diagnosis have the same needs and will respond to the same mode of treatment in the same way. SMHSC met the State's goal of providing statewide standards for treatment by establishing statewide medical necessity criteria, which did not exist prior to the program. It is interesting to note the new federal regulations governing Medicaid managed care programs require each managed care plans to establish practice guidelines, rather than requiring States' to establish practice guidelines that plans must follow.

Additional findings in this section indicate that MHPs service availability varies among counties and concern that the lack of service availability in some counties leads to beneficiaries not being served. DMH acknowledges that each MHP may not have every service modality available on an ongoing basis; however, DMH does not perceive this as a barrier to access. For example, it may not be cost or resource effective to operate a day treatment program in a given county, when only very few of that MHP's beneficiaries need that level of service. The MHP may find other effective ways to meet the beneficiaries' needs within the county or may utilize services/programs out-of-county via contractual arrangements.

Another concern raised in this section indicates that because MHPs offer varying levels of services, MHPs may grant access to only a pre-determined number of service visits. DMH acknowledges that MHPs operate using managed care principles. One such principal is pre-authorization of services. Title 9, California Code of Regulations (CCR), Section 1830.215(b) states that an MHP may require that providers obtain MHP payment authorization prior to rendering any specialty mental health service, except for emergency inpatient hospital services. Thus, MHPs may authorize a set number of service visits (excluding emergency services, which do not require prior authorization). These

services may be re-authorized if necessary. MHPs are not permitted to deny services above their standard level if medical necessity for additional services is established. Notice of action requirements for service denials, MHP grievance systems, and the State fair hearing process provide opportunities for beneficiaries to appeal situations in which they feel their MHP has incorrectly denied a service.

- ***Concern:*** **Changes to the formerly separate and distinct Fee-For-Service and Short-Doyle mental health networks (IWA, Pg. 20-21).**

The findings note that "the size and capacity of the fee-for-service provider networks has changed dramatically with the onset of the statewide waiver program." The IWA found that in most of the MHPs reviewed, the provider networks have greatly diminished. The IWA finds that "onerous regulatory requirements" are partially to blame for the diminishing networks, citing mandatory provider training, the need to make charts available to MHPs for review, and prior authorization requirements as examples of the kinds of requirements that are onerous. The IWA does not identify the baseline from which the decline in FFS provider networks was determined. DMH expected to see a decline tn the total number of former FFS/MC providers from the number participating in the Medi-Cal program prior to SMHSC. The early experience of the San Mateo County field test, which operates under a separate waiver, indicated that it would not be cost effective for the MHP or the providers to maintain contracts with providers who were willing to serve only one or two beneficiaries. The San Mateo MHP gradually phased these providers out of the program by providing incentives to providers who accepted more clients, without a negative effect on overall access.

Although the requirements that apply under SMHSC may be too costly for providers who serve very few beneficiaries, DMH does believes that these types of requirements are essential in a managed care waiver program that limits a beneficiary's freedom to choose another provider. It is also important to note that there has been significant growth in the number of "organizational" or "Short-Doyle" providers under SMHSC. Organizational providers are community-based clinics and agencies, rattler than individual providers in private practice. The number of SD/MC organizational providers has increased from 878 in FY 1996-97 to 1,499 in FY 2001-02.

- ***Concern:*** **The use of Notices of Action (NOA) to regulate and regiment access to mental health services (IWA, Pg. 21).** ***Recommendation:*** **DMH should instruct counties to issue NOAs in all cases of service denial to ensure a more comprehensive accounting of these decisions for statewide monitoring purposes (IWA, Pg. 21).**

The IWA found that: "NOAs are only issued if the MHP is the initial point of entry to the system. If a client does not meet the medical necessity criteria and the MHP is not the initial point of entry, a NOA is not issued." The IWA goes on to find that "counties are in compliance with current federal and state requirements" regarding NOAs. These findings appear to be in conflict. MHPs are required to provide NOAs when the MHP or its providers make a decision that the beneficiary does not meet medical necessity criteria to the extent that the beneficiary is not entitled to any MHP covered services

(Title 9, CCR, Section 1850.210(i)). There is no exception in regulation based on the source of the referral to the MHP .

NOAs were never intended to and do not currently serve to regulate or regiment access to mental health services, and that is not their intent. The purpose of the NOA is beneficiary protection: to notify the beneficiary of actions taken by the MHP to deny services, the reason for that action, and the beneficiary's various rights related to that action, so that the beneficiary may challenge any action the beneficiary believes was in error. Although review of NOAs serves as a useful monitoring tool, DMH does not agree that additional NOA requirements should be established for monitoring purposes. NOAs meet due process requirements; it is important that they are issued only when due process rights are involved. DMH regulations already require MHPs to issue NOAs when beneficiary due process rights are involved.

Evaluation of Quality

The IWA finds that the SMHSC has improved quality of care overall, but goes on to identify the following areas in which the reviewers believe additional improvements could be made.

- ***Concern:*** **Barriers to overall coordinated care include** a **disconnect between county-operated/contracted and network fee-for-service providers (IWA, Pg. 29).**

The IWA acknowledges that SMHSC increases opportunities for better coordination of care, but identifies concerns with the separation between the MHP's own clinics and agency contractors and the individual and group (FFS) provider networks that the reviewers observed in many of the MHPs included in the on-site component of the IWA. To the extent the MHPs use their individual and group provider networks for beneficiaries with less intensive mental health treatment needs, DMH does not believe full integration of these providers and beneficiaries into a county system of care is necessary. County systems of care are not required under SMHSC, although many beneficiaries under the waiver benefit. County systems of care involve coordination among all county agencies involved in a client's care. For example, children's systems of care typically involve the county mental health department, county social service department, county juvenile probation departments, and the local education agency. DMH does agree that clinical coordination among mental health professionals delivering services to the same client is necessary, but generally sees this as a matter of individual clinical decision-making, rather than an issue that should be resolved through state requirements and oversight.

The are seven items on page 30 of the IWA cited as specific examples of barriers to coordinated care between the MHP's own clinics and contract agency providers and the MHP's FFS provider network. Each item is discussed below.

1. "Initial referral to network fee-for-service providers may be limited to lower-end beneficiaries, while high end beneficiaries are initially referred to. either county operated or contracted providers."

DMH does not see this as a problem. In most cases, MHP clinics and agency contractors have considerable experience in providing mental health treatment to beneficiaries with more intensive, "high-end" treatment needs. FFS network providers are often less experienced in these cases, but well-qualified to handle beneficiaries with significant, but less intensive needs. DMH supported the potential distinction in regulation (Title 9, CCR, Section 1830.225) by allowing MHPs to make the initial determination to give beneficiaries the choice of at least two individual providers or, within an organizational provider, at least two of the staff providing services. Beneficiaries have the opportunity to request changes of providers if the initial choice or assignment is not satisfactory.

2. "Beneficiaries initially referred to network fee-for-service providers may not be considered part of the county system of care."

As mentioned above, county systems of care are not a required component of SMHSC. Systems of care were developed to address the complex problems of children who are seriously emotionally disturbed and adults with severe and persistent mental illness. Many beneficiaries who are served by the MHPs do not require and should not receive this level of care. Although DMH initially expected more complete integration of the former FFS/MC providers into the MHP's own clinics and agency contractors, the approach many MHPs have taken in creating a separate FFS provider network is a reasonable way to ensure that the former FFS/MC providers participate in the program and to ensure that beneficiaries are directed to the type of care best suited to their needs.

3. "County databases infrequently include information about all providers. Specifically most Management Information System (MIS) databases used to identify providers treating MHP beneficiaries include only county operated and contracted providers. They usually do not include network fee-for-service providers."

The IWA does not provide details on this concern. DMH staff discussed the issue with IWA reviewers, who indicated that the concern was that MHPs have not assigned separate provider numbers to their FFS network providers in the MHPs' MIS databases. DMH agrees that this practice puts limits on the ability of the MHPs to use their MIS to analyze the performance of FFS network providers. The MHP system issue, however, tracks back to a limit on the State's MIS. The *SD/MC* claiming system at DHS processes all federal reimbursement under SMHSC with the exception of reimbursement to FFS/MC hospitals. The *SD/MC* claiming system has limited capacity to add new provider numbers and could not accommodate individual provider numbers for each of the FFS network providers. As a compromise, each MHP was given a single provider number for all FFS network providers with the same license type, e.g., psychiatrist, psychologist, licensed clinical social worker, etc., and a number for groups of providers that included more than one type of license. The State originally found that making changes to the *SD/MC* claiming system would not be cost-effective because SMHSC was expected to move to a capitated model within a couple of years. Although that change has not occurred, the State is currently waiting for full implementation of the Health Insurance Portability

and Accountability Act's Administrative Simplification component as the trigger for making any revisions to the system.

Many, though not all, MHP databases include the same limitation that affect the State's system. The State finds this a reasonable balance between the need for information and the cost of major changes to State and MHP systems.

Regardless of the limits of an MHP's MIS, MHPs do keep track of their providers through other means. MHP contracting and credentialing processes ensure that the MHP has appropriate records of FFS network providers as well as contract agency providers. MHPs are also required to maintain a list of all MHP providers (MHP clinics, contract agencies and individual and group providers) that can be provided to beneficiaries on request. The list includes the providers' names and addresses, the category of services available from each provider, and information regarding linguistic and cultural competency.

4. "MHPs typically impose less stringent operational and/or charting requirements on network fee-for-service providers then they do on county operated and contracted providers."

5. "Network fee-for-service providers are subject to less comprehensive quality assurance and chart review standards then are county operated and contracted providers"

DMH agrees that charting and quality assurance requirements may vary among providers, but does not see this as problematic. MHPs are responsible to ensure their contracted providers meet the State's minimum documentation and quality assurance standards. Beyond that, MHPs must work out the delicate balance between ensuring an adequate provider network and ensuring quality of care through various administrative requirements. Too many administrative requirements may result in individual providers deciding not to participate in the program. The IWA sees this problem to some extent by addressing this aspect of the balance under its evaluation of quality, while identifying the concern about access in its evaluation of access (see IWA, pages 20-21).

6. "Despite consolidation, county owned and operated and contracted providers still operate on reimbursements through *SD/MC,* while network fee for service providers still operate under reimbursements from FFS/MC."

DMH regards the option in SMHSC that allows former FFS/MC providers to continue to receive reimbursement on a traditional FFS basis as a critical component in ensuring that these providers would continue to participate in mental health service delivery under the waiver. MHP clinics and MHP agency contractors must continue the pre-waiver reimbursement mechanism to obtain FFP, which involves development and submission of annual cost reports following Medicare cost reporting principles. DMH strongly believes that adding this requirement to individual and group providers would have virtually assured that the providers would have been unwilling to participate.

7. "Although counties typically require county operated and contracted providers to have progress notes to support billings, MHPs inconsistently require network fee-for-service providers to submit support for billed amounts. Network fee for service provider billings are rarely reviewed for supporting documentation."

The IWA does not describe the details behind this finding. All providers are required to progress notes in the client chart to support any billings. The DMH annual reviews include a chart review component. If a progress note is not found to support a billing, the payment is disallowed. The IWA finding may mean that some MHPs require MHP clinics and agency contractors to submit progress notes with their billings, while FFS network providers are not required to do so. If this is the case, DMH would not see the finding as a problem. MHP clinics and agency contractors are not typically required to obtain to MHP payment authorization prior to delivering a service; therefore, it would be reasonable for the MHP to require supporting documentation at the time a bill is submitted. FFS network providers are typically required to obtain this approval and to submit supporting documentation prior to obtaining the approval, making resubmission of the information at the time a bill is submitted much less critical.

Concern: **The inconsistent sharing of treatment results among providers (IWA, Pg. 30)**

DMH agrees that appropriate sharing of treatment results among providers is an important value in improving the quality of care under SMHSC. DMH continues to work with MHPs to encourage the sharing of clinical information among providers as appropriate to the mental health treatment needs of the beneficiary and within the boundaries of confidentiality standards. DMH does not agree that appropriate sharing would be improved effectively by adding new state requirements**.**

- ***Concern:*** **The inconsistent provision of case management to mental health clients (IWA, Pg. 31).**

MHPs under SMHSC are required to provide services according to the mental health needs of the individual beneficiary, following the statewide medical necessity criteria. MHPs under SMSHC cover targeted case management (TCM), which assists in linking beneficiaries with needed medical, social, educational and other services. All covered services allow treating providers, including individuals assigned as case managers, to accomplish the activities that the IWA considers "case management services," such as the identification of a client's goals and needs, development of a relationship with the client, communication with the client and the client's family, preparation of client plans and the evaluation of client status and progress. MHPs are not required to assign a case manager to every beneficiary receiving services. DMH does not believe that that level of case management is medically necessary in all cases or that it would be cost-effective to provide, even though it might provide additional opportunities for coordination of care.

- ***Concern:*** **MHPs are not at risk for cost of medications (IWA, Pg. 32).** ***Recommendation:*** **Implement a plan for monitoring medication utilization trends in order to identify unusual fluctuations and promote appropriate use of resources (IWA, Pg. 40).**

The responsibility for utilization management and payment for psychotherapeutic drugs prescribed by MHP psychiatrists rests with the FFS/MC program and, to a more limited extent, with Medi-Cal managed care plans contracting with OHS under other waiver programs. This arrangement is the arrangement that would exist without the waiver. Both the FFS/MC program and Medi-Cal managed care plans have incentives to managed drug utilization effectively. Although OMH and OHS staff assigned to SMHSC do not monitor trends, statewide trends are monitored by the FFS/MC program. FFS/MC's Utilization Review (OUR) program is designed to optimize beneficiaries' medical and pharmaceutical care and to reduce the costs of this care. OUR reviews outpatient prescribing patterns, alerts pharmacists to potential prescribing hazards and educates all providers, enabling them to render the best possible care to recipients. Additional information on this system is available at: http://files.medi-cal.ca.gov/pubsdoco/dur/DURabout.asp. In addition, OHS is currently investigating a possible problem with the prescribing of multiple atypical antipsychotic medications and is considering a number of steps, including education of providers and prior authorization requirements. OMH psychiatrists and pharmacists have been consulted in this process.

There are significant problems with the inclusion of psychotherapeutic drugs as a covered service under the waiver. Certainly MHP reluctance to assume pharmacy risk in light of the constantly changing and increasingly more costly arena of effective psychotherapeutic drugs is one of the important factors. Lack of data regarding the cost of these drugs by prescriber is also important. Psychotherapeutic drugs are prescribed by psychiatrists, but also by primary care physicians and by non-mental health specialists. Without reliable data on the historical cost of pharmacy services, it is impossible to establish the correct funding level for the services. The most critical barrier to the transfer, however, is the limitation on the State's claiming system. If the State included psychotherapeutic drugs prescribed by psychiatrists in SMHSC, the State would be required to establish edits in the FFS/MC system that would prevent these services from being paid by the State's FFS/MC fiscal intermediary .The State worked on the design of such an edit for the first several years of the planning for outpatient consolidations. The State ultimately determined that an edit by prescriber type would necessarily be based on such unreliable data that the most likely result would be a significant number of incorrect denials in the FFS/MC system, placing beneficiary health in serious jeopardy.

- **Concern: Lack of a State special incident reporting system for outpatient services (IWA, Pg. 37). Recommendations: 1. Enhance the existing special incident reporting system to include reportings on outpatient care. 2. Revise the annual compliance review protocol to include a review of such reportings.**

MHPs are required by their contract to establish special incident reporting systems for their own clinics and for their: agency contractors, but are not required to report these incidents to DMH. State licensing laws and regulations require licensed health facilities to report special incidents to their licensing agency, e.g., psychiatric health facilities report to the DMH Licensing and Certification Section.

DMH has considered requiring that MHPs report special incidents on outpatient care to the State, but has found that instituting such a system poses significant problems. The required incident reporting must focus on incidents that can be directly correlated with a mental health service. The ability to link incidents directly to services in a restricted inpatient setting is feasible, which is why the system works reasonably well under licensing laws. Linking an incident that occurs in the community to a distinct mental health service is virtually impossible. DMH will reexamine the issue in light of the IWA recommendation.

- ***Concerns:*** **1. Inconsistent statewide scope of quality assurance systems, especially pertaining to provider chart reviews. 2. Inconsistent statewide methodologies and periodicity requirements for preparation and update of assessment and client plans.** ***Recommendations:*** **1. Develop statewide guidelines and best practices to provide guidance and assistance so that MHPs can operate at the optimal level. 2. Develop a State Quality Improvement Plan to coordinate oversight efforts and support MHP (IWA, Pg. 40).**

DMH believes the regulation and contract requirements regarding MHP quality management programs have found the right balance between ensuring a minimum quality standard, while giving MHPs the ability to design programs to meet the needs of its clients within the MHP's resource limits. The minimum standard that client plans be updated at least annually seems reasonable to DMH. If some MHPs review client plans more frequently, DMH would see it as a good thing, not a problematic inconsistency. A minimum standard was not set for assessments, because DMH believes that assessment needs among clients are too variable. DMH does discuss these issues periodically, usually in the planning process for the annual compliance review process. DMH will be considering clarifications to the contract language covering client plan requirements during this year's planning process. If changes were made, they would be effective for the FY 2003-04 contract period.

DMH has been working towards improving quality of service under SMHSC. State-Ievel quality improvement efforts have been an ongoing endeavor since 1999,) with the establishment of the State Quality Improvement Council (SQIC). Membership includes a variety of stakeholders including mental health directors, beneficiary, family members, key DMH administrative, multicultural services and medical staff, public at-large members, and county mental health staff. The SQIC and the projects established as a result of SQIC efforts are represent the state-Ievel quality improvement plan. DMH coordinates its compliance-related oversight efforts through consultation with the Compliance Advisory Committee, which includes representation similar to the SQIC. DMH continues to believe, however, that the primary responsibility and authority must rest with the MHPs. The State has been committed to contracting with county mental health departments to serve as MHPs because of their extensive experience with managing the care of individuals with serious mental illness. Although we acknowledge the frustration of MHP staff when their processes are challenged by DMH reviewers, DMH does not agree that the solution is to establish "unambiguous" state standards for all areas under review. "Unambiguous" standards often have the unintended consequence of limiting appropriate care to clients who do not fit the norm.

Performance Outcomes and Data Analysis

The performance outcome system is not a SMHSC requirement, although it is one of the benefits Medi-Cal beneficiaries have obtained from the sole source exemption granted under the waiver program that allowed the State to give counties the right of first refusal for MHP contracts. Counties have communicated their concerns with the Performance Outcome system directly to DMH. DMH is working internally and with the counties to develop a standardized and useful system of performance outcome measures. DMH will continue to work directly with counties to alleviate their concerns and reduce the confusion while the system is in development.

Chart Review

- **Concern: Ambiguous statewide chart documentation and periodicity requirements lead to inconsistencies among county MHPs**

- **Concern: Absence of centralized review of treatment results from all concurrent providers is exacerbated by the infrequent sharing of charts among providers.**

- **Concern: inconsistent use of Management Information Systems, particularly by network fee-for-service providers.**

- **Concern: Inconsistent provision of case management services to mental health clients, particularly regarding assignment of targeted case managers.**

- **Concern: Infrequent and inconsistent quality assurance monitoring of provider charts, particularly of network fee-for-services providers (IWA, Pg. 55)**

- **Concern: Inconsistent statewide methodologies and periodicity requirements for preparing and updating of assessments and client plans. (IWA, Pg. 55)**

DMH comments in these areas were addressed under the responses to concerns identified in the Evaluation of Quality section above.

- **Concern: Inconsistent inclusion of quality of life assessments in client charts. (IWA, Pg. 54)**

MHPs are not required by DMH to document the Quality of Life instruments in beneficiary charts as a part of SMHSC. Quality of Life instruments have been a component of the Performance Outcome system for adults, which has its own criteria for determining the clients included in the system, unrelated to Medi-Cal eligibility. DMH would expect that only some client charts for Medi-Cal beneficiaries would include these instruments and does not consider this a problem.

- **Concern: Infrequent medication reviews by other than the prescribing physician (IWA, Pg. 54, item 6(a-e)).**

The IWA reports that most MHPs require attending psychiatrists to monitor medications at least periodically when prescriptions are refilled, but seldom require review by someone other: than the prescribing psychiatrist. MHP contracts require that the MHPs' annual quality improvement work plan include a clinical study of the safety and effectiveness of medication practices. The results of these clinical studies are unlikely to appear in client charts, although they are intended to affect the behavior of the prescribing providers. DMH believes this quality improvement approach to the issue is the most effective strategy from the perspective of a state requirement.

- ***Concern:*** **Lack of charting requirements for cultural competence, universally embraced as** a **worthwhile element of care (IWA, Pg. 54}.**

DMH has established charting requirements for some issues related to cultural competence, while other issues must be addressed in other arenas. Basic cultural competence requirements are established in regulation, which requires each MHP to establish a cultural competence plan (CCP) and to meet specific linguistic standards. MHP contracts require MHPs to comply with their CCPs. CCPs must include standards for documentation of specific cultural and linguistic issues. DMH has acknowledged that the State's approach to cultural competence is developmental, with expectations of MHP performance gradually increasing as they work with and update their CCPs. DMH continues to provide technical training and assistance to ensure improvement in MHPs documentation of cultural competence issues. In FY 2001-02, DMH first included
review items related to documentation of linguistic and cultural issues in client charts in its annual compliance review protocol. Not unexpectedly, the reviews found
deficiencies in this area for many MHPs. MHPs are required to develop plans of correction in response to these deficiencies. DMH expects to see improvement in these items in the FY 2002-03 reviews.

Advocate Group Perspectives

DMH appreciates the summary of advocacy perspectives included in the IWA. The opinions summarized here are consistent with what DMH hears directly from the stakeholders with whom we consult in the administration of the program.

Cost Effectiveness

The IWA finds that the SMHSC appears cost-effective/neutral. DMH believes that the IWA does not provide an accurate picture of the State's process for determining cost-effectiveness. Mike Geiss of Newpoint Group, the DMH contractor that has developed the methodology, has provided detailed clarifications on the findings of the IWA. These comments are attached. DMH provides the following general responses to the identified areas in which the reviewers believe additional improvements could be made.

- ***Concern:*** **The methodology used to calculate the GMS approved UPL *(Upper Payment Limit)* is based only on historical trends and does not provide accurate estimates. Use unduplicated clients instead of the number of Medi- Gal beneficiaries in UPL**

calculations (IWA, Pg. 71). *Recommendations:* 1. Revise the methodology used to calculate the UPL. The calculations should be performed by an actuary or based on a sound methodology, similar to that contained in the DHS *Upper Payment Limit Rate Methodology Manual.* 2. Use unduplicated clients instead of number of Medi-Cal beneficiaries in calculations for the UPL. Currently the statewide waiver program is not capitated and therefore, should not use the Per Member Per Month calculation in its UPL.

DMH disagrees with the findings in the area of cost effectiveness. The methodology used to calculate the CMS approved UPL is sound and provides accurate estimates. Medi-Cal beneficiaries are used in computing the UPL as recommended by the DHS *Upper Payment Limit Rate Methodology Manual.* Unduplicated clients for future years would not be known and would have to be estimated similar to the way Medi-Cal beneficiaries currently are estimated by DHS for the State's annual budget. The DHS Medi-Cal beneficiary estimate numbers are formulated by an extensive forecasting model that takes into account legislative changes, Medi-Cal enrollment changes, changes in the economy and other relevant factors. A forecasting model does not exist for unduplicated clients. DMH's use of the DHS Medi-Cal beneficiary estimates is currently the most accurate way to determine the future unduplicated clients for this program.

Per member per month (PMPM) rates should be used for the UPL calculation because CMS has treated this waiver as a managed care waiver and has requested that costs be shown on a PMPM basis.

The methodology used to calculate the UPL for SMHSC is CMS approved and utilizes a sound methodology similar to that contained in DHS Upper Payment Limit Rate Methodology Manual. Therefore, the methodology used to calculate the UPL does not require revision. SMHSC is not capitated and, therefore, does not require an actuary to perform the calculations for the UPL.

- **Concerns: 1. EPSDT costs represent 30 percent of overall waiver costs and 74 percent of increases in waiver costs for all three years. Those costs are projected to continue to grow at a large rate. 2. EPSDT costs are not tracked by MHPs because the State requires no oversight of EPSDT expenditures. Recommendation: Implement program controls requiring the MHPs to track EPSDT expenditures (IWA, Pg. 71).**

DMH believes this finding is inaccurate. As agreed between the State and CMS in previous waiver renewals, the growth in EPSDT costs are not considered a result of the waiver and would be the same without and under the waiver. Thus, the additional EPSDT growth has no impact on the absolute cost savings under the waiver and should not impair the ability to evaluate cost effectiveness under the waiver. In general, the discussion of EPSDT is not relevant to the cost effectiveness of the waiver.

The growth in EPSDT specialty mental health services costs has been an issue of concern to both the legislative and executive branches of state government over the last few years. The issue was subject to extensive budget negotiations for FY 2002-03 and as a result the State will be requiring the MHPs to provide a ten percent match for EPSDT state general fund growth above the FY 2001-02 level and providing clarification and new requirements for services that that have shown

the most dramatic growth in the last few years (day treatment and therapeutic behavioral services) to ensure that the only clinically appropriate services are being delivered.

- ***Concern:*** **Administrative costs under the statewide waiver program are greater than administrative costs without the waiver due to increased case management services. Costs are also growing at a greater than predicted rate due to administration for increasing EPSDT costs (IWA, Pg. 71).**

Administrative costs under the waiver are estimated to be slightly higher than the administrative costs without the waiver. This is attributed to the additional administrative costs associated of managing the network providers and FFS/MC hospitals that were under the former FFS/MC program, not specifically to the costs associated with providing case management or EPSDT costs. DMH believes the assessment of administrative costs in the IWA is based on incorrect assumptions. Details are provided in the Newpoint Group attachment.

- ***Recommendation:*** **Implement state monitoring of cost effectiveness (IWA, Pg. 71**).

The State does monitor cost-effectiveness under the waiver, although not through a monitoring program separate from ongoing accounting and budgeting processes. DMH, with its contractor, designed a cost-effectiveness methodology that is controlled prospectively by limiting the additional state matching funds available to the MHPs to an amount that is less than the' UPL. The State's annual budgeting process for federal financial participation in the program also provides a control (DMH knows if the budget amount is likely to be exceeded), although the payment lag of up to a year on claims and the two-year cost settlement time frame makes absolute control difficult. The high level of savings calculated for the program based on current CMS UPL requirements has provided a cushion against problems that might result from unexpected cost- settlement amounts. It is interesting to note that CMS is currently developing new cost- effectiveness criteria for managed care waiver programs that may require the State to establish a separate monitoring system. The State looks forward to working the issues through with CMS.

EVALUATION OF RESPONSE

We have received and reviewed the Department of Mental Health's (DMH) response, dated October 29, 2002, to our May 2002 Independent Assessment, *California Medi-Cal Specialty Mental Health Services Consolidation Waiver*. Attachments referenced in DMH's response have been omitted from our final report in the interest of brevity.

Before presenting our comments, we wish to clarify our position that the concerns and recommendations identified in our report are intended to assist DMH in its ongoing quality improvement and monitoring efforts. Reported concerns are not necessarily connected to specific criteria or regulations, but rather represent current trends and practices encountered during our review of the surveyed Mental Health Plans (MHPs), and may address areas where additional efficiency or effectiveness could be achieved. As indicated in our report, these areas of concern require consideration and analysis by DMH to determine the most appropriate course of action.

In general, we agree with many of DMH's comments, and appreciate the clarifications regarding certain issues raised in our report. In some cases, DMH acknowledged our concerns, but either did not perceive the concerns to be a problem, or believed that limited MHP resources would be effectively used in addressing the concerns. In other cases, DMH disagreed with of our conclusions, stating that California's Medi-Cal Specialty Mental Health Services Consolidation Waiver (SMHSC waiver program) is being implemented in compliance with laws and regulations. We reiterate that our report is based on our observations during fieldwork, and we acknowledge that policies and procedures represent intended actions, not necessarily actual implementations. Because we could not meet with staff from each county or from each DMH unit, our observations and conclusions may not be representative of statewide implementation of the SMHSC waiver program. Furthermore, we agree with DMH's assertion that some of these concerns would be present with or without the SMHSC waiver program.

For those issues in which DMH agreed with our report, a written response is not included herein. In cases where DMH fully or partially disagreed with our report, we provide the following responses:

Evaluation of Access

- *Concern:* County supplementation of the State Maximum Allowance (SMA) to recruit and/or retain particular providers.

  We appreciate DMH's clarification on this issue. Our understanding was that the SMA was a fixed maximum allowance rather than a variable maximum. Visited MHPs indicated that they would exceed this maximum only to ensure access.

- *Concern:* The uneven historical funding base for counties and the relationship it has to current utilization and penetration rates.

We do not consider this to be a fault of the SMHSC waiver program. Although it can be argued that the State's realignment process may have brought greater equity to the system, not all MHPs would agree that the system is entirely equitable. As stated in our report, MHPs may contend that system inequities prevent some counties from providing more comprehensive, higher-level services.

- *Concern:* The uneven provision of Medi-Cal reimbursable services.

  We disagree with DMH's assertion that limited service availability in some counties is not a barrier to access. Fieldwork visits to at least three small, rural counties revealed disparities in service availability. Specifically, many clients must travel out-of-county to receive needed services because such services are unavailable in their counties. This can be particularly difficult for children, who must be uprooted from their families to receive needed services, especially if required services are of an extended, inpatient nature. These issues can also be compounded by other factors, such as transportation problems, that can impede a beneficiary's ability to receive needed services.

  DMH also commented on MHPs granting access to only a pre-determined number of service visits. Our report stated that clients may be directed away from unavailable community-based treatment options and instead be treated with medications.

- *Concern:* Changes to the formerly separate Fee-For-Service and Short-Doyle mental health networks.

  DMH correctly states that we did not identify "the baseline from which the decline in FFS provider networks was determined." The determination for establishing a decline in the size of these provider networks was based on accounts provided by county MHPs during the course of fieldwork. County representatives contend that the diminished size of provider networks is attributed to "onerous regulatory requirements" imposed upon them by consolidation. Additionally, information considered instrumental in establishing a baseline was not available during the course of our review.

- *Concern:* The use of Notices of Action (NOA) to regulate and regiment access to mental health services.

  We disagree with DMH's position on the application of this regulation by the MHPs. During the course of our review, we gathered information regarding this process through interviews of MHP personnel, reviews of MHP policies and procedures, and reviews and discussions of NOAs at visited counties.

  County personnel advised us that NOAs are not issued under every circumstance when services are denied. Specifically, when a dual-diagnosed beneficiary is denied access to specialty mental health services and referred to other county services, a NOA is not issued if the beneficiary's initial point of entry was not through the MHP. We believe that counties view these referrals not as denials, but rather, as referrals to a different, more appropriate type of service. It is our understanding that if a beneficiary requests specialty mental health services and is subsequently referred to another type of service, then he/she has been refused specialty mental health services and should receive a NOA.

  We agree with DMH in its reiteration of the policy for which NOAs are issued, and that NOAs were not intended, in policy or in practice, to regulate access to mental health services. However, we also recognize that Title 9 intends a NOA to be issued in all cases

where services are denied. Our report documented a particular circumstance (discussed above) where the regulations are not being applied.

Evaluation of Quality

- *Concern:* Barriers to overall coordinated care include a disconnect between county-operated/contracted and network fee-for-service providers.

  We acknowledge DMH's agreement that "clinical coordination among mental health professionals delivering services to the same client is necessary." However, we do not believe that "this is a matter of individual clinical decision-making, rather than an issue that should be resolved through state requirements and oversight," particularly in light of the fact that the decision for clinical coordination does not appear to be prevalently made. Although new state requirements and oversight may not be the answer to ensure statewide continuity, general guidance or best practices provided by DMH may be of assistance to the MHPs. As discussed in our report and in the next *Concern* below, counties generally do not provide for a centralized review of treatment results from concurrent providers.

  Regarding the perceived disconnect between county-operated/contracted and network fee-for-service providers, we reported seven examples to which DMH provided an individual response. We reiterate that these items were intended as examples of how MHPs, despite consolidation, still view fee-for-service providers as separate from other providers.

- *Concern:* Barriers to overall coordinated care include the inconsistent sharing of treatment results among providers.

  We reiterate that it is the lack of policies and procedures that has resulted in the inconsistent sharing of treatment results throughout the state. We did not suggest that new state requirements be implemented; our intent was to illustrate that the inconsistent sharing of treatment results among providers is one example of a barrier to overall coordinated care.

- *Concern:* Barriers to overall coordinated care include the inconsistent provision of case management services to mental health clients.

  We acknowledge that potential inconsistencies may be due to the flexibility granted to MHPs to design unique mental health service delivery programs. Our position is that the general lack of statewide procedures concerning the provision of case management services has contributed to these inconsistencies. However, we did not recommend that all clients be assigned a targeted case manager. Rather, we feel that consistent application of the requirements of applicable regulations, such as the Welfare and Institutions Code, would best promote overall coordinated care.

- *Concern:* MHPs are not at risk for cost of medications.

  We discussed perceived problems regarding the State and MHP assumptions of risk for medication costs. Our report did not identify which entity should be responsible for the cost of medications. Rather, our objective was to highlight the perception that because MHPs currently have authorization responsibility, but not the associated fiscal responsibility, they may choose to prescribe medications to conserve their own limited resources. Conversely, given the volatile nature of rising medication costs, if MHPs were to be granted fiscal

responsibility, they may have to limit or disallow the use of certain medications. Both of these situations could potentially affect quality of treatment.

We concur with DMH's comments that the changing and costly nature of psychiatric medication, combined with the State's lack of reliable historical cost data and the limitation of the State's claiming system, help explain why MHPs are not at risk for the cost of medications. DMH also cites the lack of medication cost data and its inability to establish a correct funding level as additional factors that impact the decision not to transfer fiscal responsibility for medications to MHPs. However, we believe that the lack of reliable historical cost data should not be a barrier to making the transfer. Most baseline funding levels are based on estimates and some actual cost data should be available for medications.

Our report also commented on the general lack of medication oversight, both at the State and local levels. DMH responded that although DMH and DHS do not monitor trends, utilization management and trend monitoring is performed by the FFS/MC program. Without statewide monitoring of utilization trends, it would be difficult to identify and analyze unusual fluctuations, and to promote appropriate use of resources and provision of services.

- *Concern:* 1. Inconsistent statewide scope of quality assurance systems, especially pertaining to provider chart reviews. 2. Inconsistent statewide methodologies and periodicity requirements for preparation and update of assessments and client plans.

  We acknowledge that client plans are required to be updated at least annually. We reported that some MHPs are doing more frequent reviews. DMH implies that our report cited more frequent reviews as being a "problematic inconsistency." We do not view MHPs going above and beyond the minimum requirements to be a problem. We reiterate that our report attempted to illustrate disparities identified throughout the State. One disparity is that some MHPs comply with only minimum requirements; others do more.

  We disagree with DMH's explanation that it does not set a minimum standard for assessment review because "assessment needs among clients are too variable." While we agree that client needs are as varied as the clients themselves, we still contend that some minimum standard should be established to ensure that these needs are assessed and met.

  We appreciate DMH's acknowledgement of the frustration of MHP staff when their processes are challenged by DMH reviewers. However, we disagree with DMH's position that the establishment of "unambiguous" state standards will not solve this problem. DMH explains that "unambiguous standards often have the unintended consequence of limiting appropriate care to clients who do not fit the norm." While we agree that overly specific standards may have the unintended consequence of "limiting appropriate care," we nonetheless contend that additional guidance in this area is warranted, particularly in light of the fact that it is requested by MHPs. We reiterate the frustration felt by MHPs of not knowing DMH's expectations. In the absence of specific regulatory requirements, DMH, as the State authority for mental health services, should provide needed guidance in the form of statewide parameters.

Chart Review

The scope of our chart reviews was limited to a presentation of our understanding of statewide charting requirements, our fieldwork observations, and the results of our fiscal review. We assume that DMH agrees with the content of the Chart Review Chapter, except for the following two items to which DMH provided a response:

- *Concern:* Inconsistent inclusion of quality of life assessments in client charts.

  We identified that quality of life assessments were inconsistently documented in client charts throughout the MHPs visited. We are aware that there is no specific requirement that these assessments be documented in client charts. We also did not identify this as a problem but presented it for informational purposes only.

- *Concern:* Infrequent medication reviews by other than the prescribing physician.

  We acknowledge the annual clinical studies of medication practices. We stated in our report that "many MHPs provide for at least an annual review by a pharmacist, usually of between 5 percent and 10 percent of open charts." The issue mentioned here relates to an infrequent **second-level** review of medications by a person other than the prescribing physician (such as a registered or licensed vocational nurse).

Cost-Effectiveness Analysis

DMH and its consultant submitted separate responses to this portion of our report. We evaluated the comments and have made the necessary clarifications to the Cost Effectiveness Analysis Chapter of our report. Instead of responding to each individual concern, we have consolidated our responses as described below.

- *Analysis of the SMHSC Waiver Program's Cost Effectiveness*

  We agree that costs for EPSDT would be the same with or without the SMHSC waiver program. However, we included the discussion of EPSDT in the cost effectiveness analysis section because it may have a direct bearing on the UPL calculation.

  When the EPSDT agreement was implemented, it allowed MHPs to increase the amount of EPSDT costs that would not be subject to cost sharing. Therefore, MHPs now had an incentive to shift costs from existing programs to EPSDT programs. If costs from existing programs are shifted and reclassified as additional EPSDT costs, then those same costs, which were used to calculate the UPL, would be double counted. The UPL would then be overstated by the amount of existing program costs that was also accounted for as additional EPSDT costs.

  While EPSDT costs may be the same with or without the SMHSC waiver program, the effect additional EPSDT costs could have on the UPL calculation makes it a valid cost effectiveness concern. As reiterated in our report, the SMHSC waiver program appears to be generally cost effective/neutral; however, we are uncertain as to the true amount of savings due to the possible shifting of additional EPSDT costs.

- *Analysis of the Upper Payment Limit*

  In our analysis of the UPL calculation, we had concerns with the following issues: use of historical trends, computation of PMPM rates for individual service areas, and penetration rates.

  Use of Historical Trends

  The waiver renewal's cost effectiveness section appears to use historical trends, except in its estimate of future costs, which uses estimated unduplicated clients. Although we cited

one example as to why the use of historical trends may be a problem, various factors may also impact annual costs. We believe that the use of historical trends would not accurately predict changes in the environment or economy, and that the UPL computation should be performed by an actuary for a more defensible methodology.

Computation of the PMPM Rate

We agree that the costs PMPM would not be the same without and under the SMHSC waiver program. Our intent was to compare actual PMPM rates to estimated PMPM rates **under** the SMHSC waiver program. The comparison of PMPM rates was not to determine future year costs, but to determine if the components that contributed to the calculation of the UPL were accurately estimated. As stated in our report, the point of the PMPM analysis was to provide a measure of the reasonableness of the methodology used to calculate the UPL and not to re-estimate the UPL.

Penetration Rates

A comparison of actual changes in Medi-Cal beneficiaries to actual costs and unduplicated beneficiaries to actual costs was performed. The larger the number, the less a relationship exists between those two variables. The yearly average change in actual costs and the change in unduplicated clients from fiscal year 1996-97 through 2000-01 is approximately 9.48 percent. If the same analysis were conducted using Medi-Cal beneficiaries, the yearly average change would be approximately 11.88 percent. Based on this analysis, the information suggests that the change in unduplicated clients has a greater correlation to actual costs. The recommendation of using unduplicated clients versus Medi-Cal beneficiaries may provide greater accuracy to the UPL calculations.

- *Other Analyses*

The work plan suggests that we analyze other approaches to the cost effectiveness analysis, such as determining whether beneficiaries and services are decreasing. As stated in the Access Chapter of our report, access to services has been on the rise. Because mental health services have become more accessible to the public and the variety of services available has expanded, more beneficiaries are benefiting from those services. As a result, there is no evidence of a decrease in beneficiaries or services provided. As these two factors increase, so do the associated costs. We reiterate that there would be no cost savings associated with this indicator. However, we are not implying that the SMHSC waiver program was not cost effective.

The work plan also suggests analyzing the shifting of costs from the MHPs to easily substitutable FFS/MC costs. As discussed in the Quality Chapter of our report, MHPs have an incentive to prescribe medication in lieu of more therapeutic psychotherapy due to the fact that MHPs are not at risk for the cost of medications. Our intent was not to imply that this issue was a direct result of the SMHSC waiver program, but to identify it as a possible outcome. Because the State does not monitor pharmaceutical utilization rates, no further analysis could be performed to determine whether the shifting of costs actually occurs.

APPENDIX 1

Chart Review Mechanism and Summary of Results

We reviewed 156 charts[69] for 139 beneficiaries at visited counties, not including Napa County.[70] To obtain an understanding of chart review practices, we developed and asked patterned questions in each visited county. Although MHPs employ certain documentation practices, not all charts conform to these procedures. Specifically, some charts contain more or less information than required by county protocols. Unique chart organization and documentation in each county made it difficult for us to consistently apply our chart review mechanism. As such, items 4, 5, 15, and 22 may have been construed differently at each MHP.

The following table summarizes our chart review results:

[69] In four counties, results from review of multiple charts for the same beneficiary are combined. Specifically, although more than one chart may have been reviewed for each beneficiary, combined results are presented, as though only one chart was reviewed.

[70] As discussed in the Scope and Methodology section of this report, our chart review mechanism was modified subsequent to the review of Napa County. This led to inconsistencies between review results in Napa County and the remaining nine visited counties. As such, to foster continuity of presented results, Napa County is not included in our review summary.

Chart Review Mechanism and Summary of Results

Living Arrangements	
Independent Living	62
Board & Care	7
Parent/Guardian	56
Convalescent Home	1
Foster Family	13
Tot **Beneficiaries** Rev'd	139

Age Ranges	
(0-20)	71
(21-64)	59
(65+)	9
Tot **Beneficiaries** Rev'd	139

Provider Types Reviewed	
County	55
Contracted	100
Fee-for-Service	1
Tot **Charts** Rev'd	156+

	ASSESSMENT CRITERIA	ASSESSMENT RESULT				
		Yes	No	Partial	N/A	Total
Case Management						
1	Coordination of treatment (managed care) - Does chart include evidence of overall case mgt, i.e., review, by county representative or assessment team, of the results of treatment from all providers (both county and private) to ensure needs are met and services are not duplicated?	87	69	0	0	156
2	Targeted case management - Does the beneficiary have an assigned Case Manager?	101	55	0	0	156
Diagnosis						
3	Does chart indicate that beneficiary has one of the DSM IV diagnoses, which is the focus of the intervention/treatment?*	156	0	0	0	156
4	Does chart indicate that beneficiary meets the "Impairment" criteria (one of the three criteria)?*	50	102	4	0	156
5	Does chart indicate that beneficiary meets the "Intervention Related" criteria (all of the three criteria)?*	50	92	14	0	156
Quality of Life Assessment						
6	Does chart contain an Adult Performance Outcome Assessment (Quality of Life)? (Adults 18-59 in system for 60+ days, excluding "medication-only" beneficiaries)	17	48	0	91	156
7	Does chart contain a Child and Youth Performance Outcome Assessment (Child & Youth Assessment done by Parents/Guardian)? (Minors 4-18 in system for 60+ days, excluding "medication-only" beneficiaries)	37	42	0	77	156
Medication Review						
8	Does chart include evidence of evaluation of psychotropic or anti-psychotic drug meds for continuously medicated beneficiaries? Who performed evaluation?	102	0	0	54	156
9	Does chart include evidence of secondary (by other than prescribing doctor) review of prescribed medications? Who performed evaluation?	45	57	0	54	156
Cultural Competence						
10	Where applicable, is there documentation to show that services are available in the beneficiary's primary language (*if other than English*)?	17	0	0	139	156
General						
11	Does chart contain an indication that intervention (treatment) is planned rather than episodically responsive? Describe.	154	2	0	0	156

	ASSESSMENT CRITERIA	ASSESSMENT RESULT				
		Yes	No	Partial	N/A	Total
12	Does chart include evidence of Parent/Guardian or Caregiver involvement with care of minors and elderly?	84	4	0	68	156
Assessments						
13	Was a clinical assessment done since Jan-00? When? By whom (include title)? (*most recent date*)	132	19	0	5	156
14	Was the previous clinical assessment done between Jan-98 and Jan-00? When? By whom (include title)?	51	20	0	85	156
15	Does the clinical assessment include a social assessment (i.e. by a social worker)? *If Yes, skip to 18. If No, answer 16 thru 17.*	134	16	0	6	156
16	Was a social assessment done since Jan-00? When? By whom (include title)? (*most recent date*)	8	12	0	136	156
17	Was the social assessment done between Jan-98 and Jan-00? When? By whom (include title)?	5	4	0	147	156
Client (Treatment) Plans						
18	Was a Client (Treatment) Plan done since Jan-00? When? By whom (include title)?	125	24	0	7	156
19	Was the previous Client (Treatment) Plan done between Jan-98 and Jan-00? When? By whom (include title)?	46	22	0	88	156
20	Are Client (Treatment) Plan goals clearly identified and consistent with clinical assessment?	136	0	0	20	156
21	Evidence of beneficiary participation in development of Client (Treatment) Plan? (*e.g., is Plan signed by Beneficiary or Parent/Guardian? If not, is beneficiary's participation and agreement with Plan documented?*)	123	7	6	20	156
22	Does the Client (Treatment) Plan include social as well as clinical (mental health) treatment goals? *If Yes, skip to 27. If No, answer 23 thru 26.*	85	52	0	19	156
23	Was a Social Plan done since Jan-00? When? By whom (include title)?	0	63	0	93	156
24	Was the previous Social Plan done between Jan-98 and Jan-00? When? By whom (include title)?	0	16	0	140	156
25	Are Social Plan goals clearly identified and consistent with social assessment?	0	0	0	156	156
26	Evidence of beneficiary participation in development of Social Plan? (*e.g., is Plan signed by Beneficiary or Parent/Guardian? If not, is beneficiary's participation and agreement with Plan documented?*)	0	0	0	156	156
Progress Notes						
27	Are Progress Notes documenting treatment services (face-to-face visits/contact, e.g. counseling sessions) well documented and detailed?	155	1	0	0	156

** CCR Title 9, Chapter 11, Section 1830.205.*

+ In four counties, results from review of multiple charts for the same beneficiary are combined.

The following comments describe methodologies used to document results in each county.

Item 1—Coordination of Treatment (Managed Care)

Coordination of treatment can be evidenced by centralized review of treatment results from concurrent providers. None of our visited MHPs provided for this centralized review. That is not to imply, however, that no beneficiaries in these counties received coordinated care. As discussed in the body of the report, lack of centralized review mainly affects those beneficiaries who receive services from multiple providers. Beneficiaries treated by a single provider automatically have this centralized review because their treatment results are documented in a single chart.

- Yes—Beneficiary only treated by one provider at a time or in a single county that used one chart to document results of treatment from all providers.[71]
- No—Beneficiary received concurrent services from multiple providers.

Item 2—Targeted Case Management

We reviewed beneficiary charts for evidence of assigned case managers or authorization for the provision of case management services. Evidence included beneficiary information sheets, coordination plans, case management assessments, client plans, and progress notes.

- Yes—Chart evidenced that beneficiaries were assigned a case manager (or differently titled staff with the same responsibilities)[72] or were approved for case management services.
- No—Charts contained no evidence to suggest that targeted case management services were being provided. Beneficiaries not targeted for case management may have received case management type services from other staff including their clinicians, a service coordinator, or other staff involved in their treatment.

Item 3—DSM IV Diagnosis

Beneficiaries must meet medical necessity for specialty mental health services to be reimbursable. To meet medical necessity, beneficiaries must have a DSM IV diagnosis. Although each MHP documents diagnoses in different ways (i.e., some counties include a diagnosis as part of the clinical assessment while others use a separate form), we observed a documented diagnosis in each chart we reviewed.

Items 4 and 5—Impairment and Intervention Criteria

Title 9[73] states that beneficiaries must meet intervention and impairment criteria as a result of their diagnosis for mental health services to be reimbursable. This item was subject to judgmental interpretation because each MHP employs different documentation standards. Specifically, some counties use a medical necessity form to indicate how beneficiaries meet medical necessity. Others include a statement on assessments or client plans. Some do not explicitly mention medical necessity at all.

[71] One small rural MHP with a provider network of less than 10 facilities located within ten miles of each other used a single chart to document treatment delivered by those providers, with the exception of the inpatient hospital.
[72] Some County MHPs used the term “service coordinator” synonymously with “case manager.”
[73] CCR, Title 9, Chapter 11, Section 1830.205.

- Yes—Charts that include a specific form to document how medical necessity is, and continues to be met.
- No—Charts that do not include specific documentation of how medical necessity is met.
- Partial—Charts that include a specific form to document how medical necessity is met, but the form is no longer required or is not required to be updated (i.e., to show that medical necessity continues to be met).

Item 6—Quality of Life Assessments (Adult)

Refer to the Performance Outcome Data Analysis Chapter for a complete discussion of adult performance outcome measures.

- Yes—Charts include a completed CA-QOL or contain written evidence of beneficiary's refusal to complete[74] a CA-QOL.
- No—Charts do not include a completed CA-QOL or evidence of beneficiary's refusal to complete where one appears warranted.
- N/A—Beneficiary is a minor, not in the system for 60 days, or medication-only.

Item 7—Quality of Life Assessments (Child/Youth)

Refer to the Performance Outcome Data Analysis Chapter for a complete discussion of child/youth performance outcome measures.

- Yes—Charts include a completed YSR or contain written evidence of beneficiary's refusal to complete[75] a YSR.
- No—Charts do not include a completed YSR or written evidence of beneficiary's refusal to complete where one appears warranted.
- N/A—Beneficiary either an adult, not in the system for 60 days, or medication-only.

Item 8—Medication Review by Prescribing Physician

All MHPs provide that medications must be prescribed and monitored for effectiveness and side effects by the attending psychiatrist.[76] We observed evidence of medication monitoring by the prescribing physician in all cases where medications were prescribed.

Item 9—Secondary Medication Review

Counties infrequently require a quality review by a second person. In some counties medications are prescribed by psychiatrists and monitored by Registered Nurses or Licensed Vocational Nurses (collectively "nurses"). Although nurses are not expected to second-guess prescribing psychiatrists, they can identify issues or concerns that arise from meetings with beneficiaries or chart status reviews. When performed, these secondary reviews are usually evidenced in beneficiary charts through progress notes and medication logs.

[74] Client completion of the CA-QOL is voluntary. We looked for evidence that the provider at least attempted to have one completed.
[75] Client completion of the YSR is voluntary. We looked for evidence that the provider at least attempted to have one completed.
[76] Nurse Practitioners can also prescribe medications under the supervision of a cosigning psychiatrist.

- Yes—Chart includes evidence of secondary medication review by other than the prescribing physician.
- No—Chart does not include evidence of secondary medication review.
- N/A—Beneficiary not prescribed medications.

Item 10—Cultural Competence

Although most beneficiaries were English speakers, we did observe some consideration to cultural competency issues in charts. Specifically, some MHPs documented attention to cultural diversity on assessments or client plans. Others did not. Additionally, although we did not observe assessments or client plans to be available in languages other than English, some counties documented whether translation of these forms was necessary.

- Yes—Chart indicates a beneficiary has specific language needs and documents that these needs are addressed (e.g., through a translator or a clinician with similar language background).
- N/A—Beneficiary was English speaker with no specifically identified language needs.

Item 11—Planned Intervention

For this item we looked for evidence that treatment was planned rather than episodically responsive. Specifically, if beneficiaries were seen simply in response to presentation for crises or emergencies, it would not appear that treatment is planned. We determined that although treatment is often triggered by episodic presentation by a beneficiary (e.g., to an emergency room or crisis unit), care is more planned than episodically responsive. That is, once beneficiaries present, providers attempt to plan their care and interventions. We observed evidence of appointment follow-up and other documented contact attempts in beneficiary charts.

- Yes—Chart included evidence (e.g., progress notes, scheduled appointments, client plans, etc.) that providers attempted to plan care and interventions.
- No—Beneficiaries only received an initial assessment and did not return for services. No client plans were prepared.

Item 12—Parent/Guardian/Caregiver Involvement in Treatment

WIC states that "the development of the (client) plan should include the participation of the beneficiary, family members, friends, and providers of services to the beneficiary, as appropriate."[77] MHPs involve beneficiary families to different extents. Although family/support system involvement can be an important part of beneficiary interventions, it can be more difficult to involve family/friends of adults than for children, youth, and older adults who can be more dependent on a support network than adults. Additionally, many adults do not have a support network. As such, involvement of family/friends may be more prevalent for children, youth, and older adults.

- Yes—Beneficiary was a minor whose progress notes, client plan and/or other chart documents evidence involvement of his/her parent/guardian.

[77] WIC Section 5600.4(c).

- No—Beneficiary was a minor whose chart included no evidence of parent/guardian involvement.
- N/A—Beneficiary was an adult.

Items 13 and 14—Clinical Assessments Since January 1998

WIC requires that MHPs provide comprehensive evaluation and assessment as part of their offered array of treatment options.[78] Neither regulatory nor contractual requirements specifically define rules for assessment periodicity. While some counties had no requirement that assessments be updated, others required formal updates at various intervals ranging from twice a year to every three years. For our review, we judgmentally selected assessments in two-year periods starting in January 1998. That is, if a provider treated a beneficiary since the beginning of 1998, we looked for two formal assessments, one between January 1998 and December 1999 and one since January 2000.

- Yes—Chart included a clinical assessment for beneficiaries during the stated period.
- No—Chart did not include a clinical assessment for beneficiaries during the stated period.
- N/A—Beneficiary not in the system during the stated period.

Item 15—Clinical Assessments Include Social Assessments

Although current laws and regulations neither require the use of standard assessment forms nor specify what elements assessments should include, we looked for evidence that clinical assessments also included an evaluation of beneficiaries' social symptoms. These might include such issues as housing, finances, and day-to-day functioning levels.

Although most county representatives state that they intend their clinical assessments to be all-inclusive, chart reviews required judgment and interpretation. Specifically, because assessment forms differed by county, it was not always clear which forms included social evaluations and which did not.

- Yes—Chart included a comprehensive assessment covering both clinical and social aspects of beneficiary impairment.
- No—Chart included an assessment limited to clinical issues.
- N/A—Beneficiary not in the system long enough to warrant an assessment.

Items 16 and 17—Social Assessments Since January 1998

Some MHPs require separate assessments by each professional delivering service within a provider facility. Specifically, one county may provide a separate assessment by a case manager, a clinician, and a psychiatrist for beneficiaries authorized for case management, psychotherapy, and medications, while another MHP may use an all-inclusive clinical assessment. In counties where assessments were limited to evaluation of clinical aspects of a beneficiary's situation, we looked for a separate assessment of the beneficiary's social needs. Following the timeframes established during our review of clinical assessments, we looked for social assessments in two-year intervals since January 1998.

[78] WIC Section 5600.4.

Some charts include both clinical and social assessments. Although we observed this infrequently during our review, our goal was to determine whether MHPs provided for an assessment of both clinical and social needs, and not necessarily to identify how many times each was evaluated.

- Yes—Chart included a social assessment for beneficiaries in the system during the stated period.
- No—Chart did not include a social assessment for beneficiaries in the system during the stated period.
- N/A—Beneficiary not in the system during the stated period.

Items 18 and 19—Client Plans Since January 1998

WIC requires that MHPs provide individual client plans as part of their array of treatment options.[79] Although regulatory requirements do not specifically define rules for client plan periodicity, the DMH contract requires plans to be prepared at least once a year. Most MHPs require updates at various intervals ranging from three to twelve months, depending on need. For continuity purposes, we judgmentally reviewed plans in the same two-year periods as we did for assessments, namely January 1998 through December 1999 and January 2000 forward.

- Yes—Chart included a client plan for beneficiaries during the stated period.
- No—Chart did not include a client plan for beneficiaries during the stated period.
- N/A—Beneficiary not in the system during the stated period.

Item 20—Client Plan Goals Identified and Consistent with Assessment

Although regulatory requirements do not specifically govern content of client plans, the DMH contract requires plans to "have specific observable and/or specific quantifiable goals consistent with the diagnoses."[80]

- Yes—Client plans included clearly identified goals. Although goals were broadly stated in some cases (e.g., "to decrease target symptoms"[81]), most were specific and defined.
- N/A—Chart did not include a client plan.

Item 21—Evidence of Beneficiary Participation in Client Plan

Current laws and regulations do not require the use of standard client plan forms nor specify what elements should be included. However, the DMH contract does require that client plans include documentation of beneficiary participation in and agreement with the plan (e.g., beneficiary signature or description of beneficiary involvement).[82]

- Yes—Client plan was signed by the beneficiary, parent, or guardian.
- No—Chart includes neither a signed plan nor evidence of beneficiary participation in plan development.
- Partial—Plan was not signed but chart includes documentation that the beneficiary participated in plan development.

[79] WIC Section 5600.4.
[80] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C, Item B.
[81] Observed on a client plan in one small northern county.
[82] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C, Item B.

- N/A—Chart did not include a client plan.

Item 22—Client Plans Include Social Goals

Although client plans are usually intended to address all aspects of treatment, most plans tend to address amelioration of clinical symptoms. The beneficiary's social needs may be addressed separately by assigned case managers. Chart reviews required judgment and interpretation. Specifically, because client plan forms differed by county, it was not always clear which forms included social goals and objectives and which did not.

- Yes—Client plan addressed both clinical and social goals and interventions.
- No—Client plan goals and interventions were limited to addressing clinical issues.
- N/A—Chart did not include a client plan.

Items 23 and 24—Social Plans Since January 1998

Some MHPs allow or require separate client plans for clinical and social aspects of treatment. In counties where we observed that plans were limited to an evaluation of clinical aspects, we looked for a separate plan that covered beneficiaries' social needs. For continuity, we followed timeframes established above and looked for social plans every two years since January 1998.

Some charts include both clinical and social plans. Although we observed this infrequently during our review, our goal was to determine whether MHPs provided planned care for both clinical and social beneficiary needs, not necessarily to identify how many times each was evaluated.

- No—Chart did not include a social plan for beneficiaries during the stated period.
- N/A—Beneficiary not in the system during the stated period.

Item 25—Social Plan Goals Identified and Consistent with Assessment

We observed no social plans other than those prepared in conjunction with an all-inclusive client plan. As discussed in items 23 and 24 above, we did not document separate social plans when client plans included social goals.

Item 26—Evidence of Beneficiary Participation in Social Plan

See item 25.

Item 27—Progress Notes

Although neither WIC nor Title 9 specifically address progress notes, the DMH contract provides that progress notes must be timely, legible, signed, and must document "relevant aspects of care including beneficiary encounters with mental health staff/practitioners, clinical decisions, and interventions."[83]

[83] DMH/MHP Contract, Exhibit A, Attachment 1, Appendix C, Item C.

- Yes—Chart included detailed documentations of beneficiary visits and contacts with other parties or providers. Progress notes documented case management services and discussions during therapy, group sessions, and medication visits, as applicable.
- No—Chart did not include progress notes because beneficiary presented only once for initial assessment and did not return for treatment.

Results Summary for Annual Compliance Reviews

The table below summarizes the results of the annual compliance reviews (review) for the selected MHPs. Staff summarized reviews conducted during fiscal year 2000-01 for eight of the ten counties. The reviews for Orange County and Placer County were conducted during 2001-02 and the results were not available at the time of our compilation.

The purpose of summarizing the questions was to produce a condensed table that accurately reflects the reviews' results. Common subjects under each section of DMH's Annual Review Protocol For Consolidated Specialty Mental Health Services were combined into one summarized question. The total number of combined questions is next to each summarized question in parenthesis. Responses that were not applicable to individual counties were not included in our compilation.

		In Compliance?		
		Yes	No	% in compliance
	Section A Implementation Plan			
1.	MHP has approved implementation plan that includes a plan for cultural competence. (3)	22	5	81.5
	Total of Section A	22	5	81.5
	Section B Access			
1.	Adequate plans for communication and access with the community including diverse ethnic populations through ads, 24 hour hotline, and 24/7 Services for Urgent conditions. (18)	165	12	93.2
2.	Medical need and rights for all beneficiaries, including all ethnic groups are being met by MHP. (6)	57	3	95.0
3.	System in place for screening beneficiaries and coordination for all their benefits. (1)	10	0	100.0
4.	Access for Cultural /Linguistic beneficiary appropriate and are language services provided. (20)	183	11	94.3
5.	Therapeutic Behavioral Services (TBS) processes are adequate. (6)	60	0	100.0
	Total of Section B	475	26	94.8

		In Compliance?		
		Yes	No	% in compliance
	Section C Authorization Process			
1.	County MHP process exists for admissions into hospital for all beneficiaries. (4)	39	1	97.5
2.	Process for Treatment Authorization Request adequately meets the needs of all beneficiaries including appeals process. (5)	49	1	98.0
3.	Non-Hospital mental health services process in place to serve beneficiaries. (3)	27	0	100.0
4.	MHP annually reviews Utilization Management activities for consistency including Notice of Actions. (13)	79	3	96.3
	Total of Section C	5464	141	97.5
	Section D Beneficiary Protection			
1.	MHP's process for problem resolutions allows for grievance process and complaint resolution. (21)	202	8	96.1
	Total of Section D	202	8	96.1
	Section E Contracts			
1.	Contracts between MHP and disproportionate share and traditional hospital that meets election criteria, and have a request for exemption approved. (2)	5	5	50.0
	Total of Section E	5	5	50.0
	Section F Health and Safety			
1.	MHP's system to require contracted individual, group provider, and Non-MHP organization to have necessary licenses and certificates to practice psychotherapy and to be in compliance with all regulatory DMH requirements is adequate. (8)	70	0	100.0
2.	MHP's process for handling and dispensing medication is reasonable. (9)	64	0	100.0
	Total of Section F	134	0	100.0
	Section G Interface with Physical Health Care			
1.	Memos of Understanding are in place, with all Medi-Cal Managed Care Plans, that cover proper procedure for providing and receiving referrals, consulting and training on medications, regulating and maintaining confidentiality of records, providing covered services, and resolving dispute with Medi-Cal Managed Care Plans. (8)	53	1	98.1
2.	MHP Coordinates with Primary Care Providers and other qualified health centers in consulting and training, regulating and maintaining confidentiality of records, and providing approved prescription drugs and laboratory services. (7)	70	0	100.0
	Total of Section G	123	1	99.2

		In Compliance?		
		Yes	No	%
	Section H Provider Relations			
1.	A process for the resolution of payment authorizations and other complaints fairly and quickly between the MHP and the provider is adequate. (4)	35	5	87.5
2.	MHP gathers information from providers regarding its Utilization Management activities. (2)	13	7	65.0
	Total of Section H	48	12	80.0
	Section I Quality Improvement (QI) Activities			
1.	QI Program includes all stakeholders. (4)	40	0	100.0
2.	QI committee operating within the guidelines of the QI Plan. (9)	86	4	95.6
3.	QI work plan exist and effectively monitors previously identified issues. (21)	188	21	90.0
4.	Written Agreement exist that spells out delegated QI activities along with documentation of MHP oversight of those activities. (8)	32	8	80.0
5.	MHP's policy, procedures and practices effectively evaluate staff and implement training programs in culturally competent services. (8)	74	6	92.6
6.	Utilization Rates are tracked for all beneficiaries. (4)	35	5	87.5
	Total of Section I	455	44	91.2
	Section J Non-Hospital Services			
1.	MHP's verifies Beneficiaries meet all criteria for reimbursement. (11)	109	1	99.1
2.	Client plans meet all required elements. (27)	234	19	92.5
3.	Beneficiaries meet cultural/linguistic service requirements. (5)	36	1	97.3
	Total of Section J	379	21	94.8
	Grand Total	**1,957**	**127**	**93.9**